STATE COVERAGE INITIATIVES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

JULY 15, 2008

Serial No. 110–91

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
49–690 WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON WAYS AND MEANS

CHARLES B. RANGEL, New York, *Chairman*

FORTNEY PETE STARK, California
SANDER M. LEVIN, Michigan
JIM MCDERMOTT, Washington
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. MCNULTY, New York
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
LLOYD DOGGETT, Texas
EARL POMEROY, North Dakota
STEPHANIE TUBBS JONES, Ohio
MIKE THOMPSON, California
JOHN B. LARSON, Connecticut
RAHM EMANUEL, Illinois
EARL BLUMENAUER, Oregon
RON KIND, Wisconsin
BILL PASCRELL, JR., New Jersey
SHELLEY BERKLEY, Nevada
JOSEPH CROWLEY, New York
CHRIS VAN HOLLEN, Maryland
KENDRICK MEEK, Florida
ALLYSON Y. SCHWARTZ, Pennsylvania
ARTUR DAVIS, Alabama

JIM MCCRERY, Louisiana
WALLY HERGER, California
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
SAM JOHNSON, Texas
PHIL ENGLISH, Pennsylvania
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri
RON LEWIS, Kentucky
KEVIN BRADY, Texas
THOMAS M. REYNOLDS, New York
PAUL RYAN, Wisconsin
ERIC CANTOR, Virginia
JOHN LINDER, Georgia
DEVIN NUNES, California
PAT TIBERI, Ohio
JON PORTER, Nevada

JANICE MAYS, *Chief Counsel and Staff Director*
JON TRAUB, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH

FORTNEY PETE STARK, California, *Chairman*

LLOYD DOGGETT, Texas
MIKE THOMPSON, California
RAHM EMANUEL, Illinois
XAVIER BECERRA, California
EARL POMEROY, North Dakota
STEPHANIE TUBBS JONES, Ohio
RON KIND, Wisconsin

DAVE CAMP, Michigan
SAM JOHNSON, Texas
JIM RAMSTAD, Minnesota
PHIL ENGLISH, Pennsylvania
KENNY HULSHOF, Missouri

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

STATE COVERAGE INITIATIVES

TUESDAY, JULY 15, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:04 a.m. in Room 1100, Longworth House Office Building, Hon. Fortney Pete Stark [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 08, 2008
HL–27

CONTACT: (202) 225–3943

Chairman Stark Announces a Hearing on State Coverage Initiatives

House Ways and Means Health Subcommittee Chairman Pete stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on State Coverage Initiatives. **The hearing will take place at 10:00 a.m. on Tuesday, July 15, 2008, in the main committee hearing room, 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

With a growing number of uninsured individuals and limited action on the federal level, states are tackling health care reform. Several states have attempted to initiate health care reform to cover significant portions of the uninsured residents in their states. In the 1970s, Hawaii was the first state to try and achieve universal health care coverage. More recently, 3 states, Massachusetts, Vermont and Maine, have enacted universal coverage initiatives.[1] An additional 14 state Governors and legislatures have proposed universal coverage. Early results from Massachusetts have been encouraging, although key challenges remain. Massachusetts has expanded affordable coverage to 355,000 people by establishing new coverage programs, setting individual affordability standards and penalties to implement an individual mandate, and launching new requirements for employers. Massachusetts is offering valuable lessons to other states and the nation.

However, even though a few states are finding the funding and pursuing bold coverage initiatives, the vast majority of states have either been unable to implement major initiatives or have not even attempted to do so. In fact, many of the states that have attempted health reform have done so leveraging federal Medicaid and State Children's Health Insurance Program (SCHIP) funding and still must consider long-term financing for their programs. Annual balanced budgeting, differences in the percent of uninsured and variation in states' average incomes are just a few reasons why some states have a much higher burden to implement health care reform. A state-by-state approach to health care reform would result in vast variation in coverage across the nation, as some states decide to implement universal coverage and others do not.

In announcing the hearing Chairman Stark said: **"Comprehensive health reform must be a priority for the next President and Congress. I welcome the opportunity to learn from state efforts as Congress considers health solutions in the coming year. It is important we understand the successes and difficulties of the states as we prepare to embark on national health care reform."**

---

[1] *http://www.kff.org/uninsured/kcmu*_statehealthreform.cfm

FOCUS OF THE HEARING:

The hearing will focus on the health care reform lessons learned at the state level as well the need for a national solution on health care reform.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov, select "110th Congress" from the menu entitled, "Committee Hearings" (http://waysandmeans.house.gov/Hearings.asp?congress=18)*. Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Follow the online instructions, completing all informational forms and click "submit". Attach your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, July 29, 2008**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, and telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at http://waysandmeans.house.gov.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. Welcome. We will begin our hearing on state health initiatives. And we have often felt that one of the ways to achieve affordable health care is to have several of our major states lead the way. And Federal Government would then be called in to see that comprehensive reform would combine the state's efforts and the federal efforts to get us to a national plan. The U.S. would then finally join the rest of the industrialized world in ensuring that everyone has access to affordable health care.

Now, unfortunately, the—given the experience to date, it seems unlikely that any one state will set the basis for the nation.

Today's witnesses include experts and officials who have been at the forefront of state reform efforts. And I believe we will hear that it's very difficult for them to move forward, one at a time, and achieve complete uniform affordable coverage for every resident.

However, a few states have been able to make remarkable gains in reducing the number of uninsured, and many are hampered by numerous issues: state balanced budget requirements, volatile financing, the need for Federal waivers from ERISA and other Federal laws. All of those are challenging states' programs.

Canada achieved universal health care, just as I described, one province at a time. But that was four years ago, and we face a different situation. We have a larger and more diverse population. Health care costs have risen tremendously, and special interests have grown ever more entrenched and committed to maintaining the status quo.

So, while we have made progress here, states have been trying health care reforms for the last four decades, and we have relatively few successes in those that have tried, and many states haven't even attempted. It seems there will always be states that are unable to implement these reforms on their own, for one reason or another.

But today we will hear from a panel of experts that include state officials who study and aid state policy makers. I look forward to hearing their testimony, and we hope we can learn from their experience, both the successes and failures, as we begin to consider health care reform for our Nation.

My premise may still hold true, that the states will lead the way and bring the Federal Government kicking and screaming to the table, but there is an important caveat. Instead of needing several states to achieve universal health care, we simply need several key states who are trying to meet that goal, and can show us the way that we can, through a state and Federal partnership, achieve that goal.

I think today we will hear that there is no lack of commitment at the state level, but states hit road blocks in every way. So I look forward to the testimony of our witnesses, and I would like to ask Mr. Camp if he has any opening remarks.

Mr. CAMP. Well, thank you, Mr. Chairman. And thank you for convening this hearing on state health care reforms.

In recent months, this subcommittee has heard testimony on the many challenges facing our health care system. Each of those hearings has broadened the debate on health care reform, and, I believe, highlighted the need to address this issue sooner, rather than later.

Today, we will hear directly from the states which are on the frontlines of this battle. Many states, including those testifying today, have taken steps to ensure their citizens have adequate access to the health care system. And, Mr. Chairman, I believe this could be one of the most important hearings we have this year, because, at the end of the day, to make significant reforms in our health care system, we will need to work hand in hand with state governments.

In fact, much of the work being done at the state—by the states on health care reminds me of welfare reform in the early nineties. And many on this Committee will remember that before we enacted the 1996 welfare reform law, states like Wisconsin and Michigan had already begun to make changes to their welfare programs.

Instead of enacting overly broad national mandates, we gave great—the states greater resources and flexibility to craft programs that fit their own populations. And I think the lessons we learned from that reform a decade ago can be applied to health care. It is my opinion that states are the most appropriately situated to design health care plans that meet the needs of their citizens. And Congress should be looking at what works and what does not work in the states.

Even more importantly, we should be breaking down the barriers that are preventing states from trying to address their own difficulties. And we will hear today that many of the successes in the states were only possible through waivers of existing law by CMS and HHS. So, who would have thought that the answer lied with eliminating unnecessary, burdensome, and unworkable Federal mandates?

As we look at what the states are doing, we must not overlook the single largest obstacle for providing health insurance: the discriminatory tax treatment for individuals who purchase health insurance on their own. To spur the expansion of health coverage after World War II, Congress gave employers a huge tax benefit to offset the costs of providing health care to their employees.

This led to our current model today, where you either get care through the government or an employer. Eighty-5 percent of all Americans receive health care through their employer, and this has left upward, depending on how you count it, 40 million Americans uninsured or under-insured. I firmly believe we must address this inequity in the tax treatment with other reforms to adequately address the issue of health coverage.

Mr. Chairman, this is an important issue. I don't think is necessarily a Republican issue or a Democrat issue. And when we talk about health care, it shouldn't matter which party you're in. We really must talk about an American solution. And I believe we can work together to support the states and their efforts to craft innovative solutions. But we must also be forward-thinking and develop new solutions for the millions of Americans that are demanding health care choices.

Again, thank you, Mr. Chairman, for calling this hearing. And, with that, I yield back.

Chairman STARK. Thank you. We're going to have one panel this morning. Alan Weil, who is the executive director of the National Academy [sic] for State Health Policy—a peek at his testimony suggests that he is going to give us an overview of the progress that states have made. In the late nineties, Mr. Weil was the state Medicaid commissioner for the Democratic Governor of Colorado.

We will hear from Dr. JudyAnn Bigby, who is Secretary of Health and Human AServices for the Commonwealth of Massachusetts. Secretary Bigby will provide, we believe, an overview of the

implementation of their coverage initiative and its progress to date, and perhaps discuss the challenges ahead.

Dr. Jack Lewin is familiar to many of us. He made a terrible, terrible mistake in his career path years ago when he left the great state of Hawaii, because we could have had the hearing there if he was still there. He moved from Hawaii—I must say moved up to the great state of California—and now is chief executive officer of the American College of Cardiology. I don't know just what Jack is going to tell us about, but I am sure he will discuss Hawaii's—I think first state to mandate coverage for all residents. And back in 1986, whenever that started, and what's happened to that since, and I think we will find that interesting.

Mr. Haislmaier, with the Heritage Foundation, and he has worked with several states in designing their health reform initiatives. I think he will talk to us about the themes that states have raised during his work, and the challenges they face. He is a strong proponent of consumer-driven health care, and is going to give us some alternatives to the plans that are on the books.

Ms. Trish Riley is the director of Maine Governor's Office of Health Policy and Finance. She will talk about Governor Baldacci's successful passage of a comprehensive health reform act, the Dirigo Heath Reform Act of 2003, and advise us to how that is doing, and whether or not our former colleague can run for reelection on the success of that plan, or whether he should look to his cousin success in writing mystery novels, and perhaps move that way.

So, we will just start down with the panel. Mr. Weil, if you would like to lead off, if you each want to take about 5 minutes to summarize, I am sure that the Members will want to inquire in more depth as you complete your testimony. Please proceed.

STATEMENT OF ALAN R. WEIL, EXECUTIVE DIRECTOR, NATIONAL ACADEMY FOR STATE HEALTH POLICY

Mr. WEIL. Thank you, Chairman Stark, Ranking Member Camp, distinguished Members of the Committee. My name is Alan Weil, I am the executive director of the National Academy for State Health Policy. NASHP is a non-profit, non-partisan organization that works with leaders in state health policy to identify emerging issues and address challenges in state health policy and practice.

This is an exciting time for states in our Nation, as the call for significant health care reforms grows louder. States are considering and implementing innovative and promising strategies to reverse the trend of an increasing number of Americans without health insurance.

Yet, given the barriers states face, my overarching message to you today is that states cannot do this alone. Federal leadership is required. In the absence of Federal action, a broad array of states in all regions of the country representing quite varied ideological perspectives is pursuing health reforms. You will hear about some of these efforts from other witnesses.

But despite successes, the states' ability to address our health care challenges is limited. States are constrained for many reasons. They lack authority to affect many of the health care activities within their borders. About half of a typical state's residents are completely outside the reach of state authority, because they are

enrolled in Medicare, have coverage through an employer that self-insures, or obtains services through various Federal programs.States face budgetary constraints, due to balanced budget requirements, and due to Federal policy that requires that Medicaid waivers be budget-neutral with respect to Federal costs. Expecting states to address the many vexing health policy issues on their own is unrealistic, and constrains the number of states that can even make such an effort.

Given these challenges, it is not surprising that only three states in the last decade—Maine, Vermont, and Massachusetts—have adopted comprehensive reforms, and efforts in larger states, such as California, Illinois, and Pennsylvania, remain stalled.

Now, while state efforts make a real contribution, Federal leadership is needed to make substantial sustained progress in health reform. Federal leadership could take several forms, including one that provides a substantial role for states to operate within a national framework. Indeed, approaches that combine the resources, stability, and uniformity of Federal involvement, with the dynamism of local involvement and creativity of states, can foster excellent results.

The Federal Government can bring its clout, as the largest purchaser, and stable funding to weather economic ups and downs, and standards that ensure that all Americans have meaningful access to needed services. States can design the details of a plan to conform to local market and medical practice conditions, develop models that enable us to learn what does and does not work, and ensure that program operations reflect local values. Federal waivers, though helpful in some instances, are no substitute for a clear, Federal commitment.

Federal leadership is required, if we are to bring down unwarranted variation across the country in health care practice and costs. A recent Commonwealth Fund report describes interstate variation in the use of antibiotics to reduce the risk of infection during surgery. Variation across states in the share of the adult population without health insurance has existed for decades. And in recent studies, they have ranged from a high of 35 percent in Texas to a low of 11 percent in Minnesota. National requirements, resources, and benchmarks can all serve to close some of these gaps.

The importance of Federal leadership is clearly demonstrated in the contrast between our recent experience covering adults and children. For adults, we have no national coverage strategy. Medicaid, which is the nation's primary commitment to health care to the poor, explicitly excludes non-elderly adults, unless they have a disability or dependent children.

For children, we have a national strategy. Despite some limitations, Medicaid and SCHIP extend coverage to nearly all children in families with incomes up to twice the poverty level. And the contrast, then, is stark. Between 1996—1999 and 2006, the percentage of uninsured adults increased in 43 states, while the percentage of uninsured children decreased in 32 states. The combination of a national priority with the resources to support it and state flexibility and the methods for achieving it can yield tremendous results.

In my job, I have the opportunity to speak to many state officials. Their message is surprisingly consistent, regardless of job title, political affiliation, or state. They are doing what they can to address issues and problems that are bigger than the resources available to them. They are eager for Federal leadership, they feel its absence, but they are also nervous about a heavy-handed or one-size-fits-all approach.

A true Federal solution to our health care problems requires something like a joint venture: cooperation between the Federal Government and the states that states have not seen lately. Delays in SCHIP reauthorization, CMS's August 17th letter, the new Medicaid citizenship and identity documentation burdens have all impeded state efforts to cover more folks.

Ultimately, in the absence of federal action, states will lead and states will accomplish as much as they can, given the constraints they face. But piecemeal state action will never add up to what the nation needs. A national response that honors the history of American Federalism would include a series of national commitments to universal coverage, improved access and quality, and tempering cost growth that frame and support what states can do.

I thank you for the opportunity to appear before the Committee today.

[The prepared statement of Mr. Weil follows:]

Statement of Alan Weil, Executive Director, National Academy for State Health Policy

Chairman Stark, Ranking Member Camp and other distinguished Members of the Ways and Means Health Subcommittee, my name is Alan Weil and I am the Executive Director of the National Academy for State Health Policy (NASHP). NASHP is a non-profit, nonpartisan organization that has worked with state leaders for more than two decades helping them to identify emerging issues and address challenges in state health policy and practice. NASHP seeks to amplify the voice of state health officials and support interstate learning—roles that we believe will be particularly important as health care rises on the national agenda.

This is an exciting time for states and our nation as the call for significant health care reforms grows louder. States are considering and implementing innovative and promising strategies to reverse our nation's trend of an increasing number of Americans without health insurance. Yet, states face substantial limitations in what they can accomplish in the absence of further support at the national level. States have demonstrated critical leadership and hold great promise for the success of any major coverage reforms, but states cannot do this alone. States need a national framework in order to achieve the promise of health reform—a framework of federal support, assistance, and guidance. I will discuss each of these points in my testimony [1]

1. **States are leading the way addressing major health system challenges.**

In the absence of federal action, states are leading the way in addressing many of the major challenges facing the American health care system. States are responding to the concerns raised by families, businesses, and health care providers and have made progress in improving access to health coverage, containing health costs, and improving quality.

A broad array of states in all regions of the country representing quite varied ideological perspectives is pursuing health reforms. Some state efforts are comprehensive in scope; others focus on particular problems facing the health care system. Although Massachusetts has received the most attention recently for its groundbreaking reforms that have already cut the number of people without health insurance in their state by half, many other states are also making real progress toward this goal. Iowa recently passed legislation to improve enrollment and retention for children in public programs and strengthen consumer protections in the pri-

[1] Much of this testimony draws from my article "How Far Can States Take Health Reform?" which appeared in the May/June 2008 issue of *Health Affairs* at pages 736–747.

vate market. Wisconsin has taken advantage of options available under the Deficit Reduction Act to expand coverage to parents and children and simplify and modernize its Medicaid and SCHIP programs. Louisiana is a leader in providing coverage for low- and moderate-income children.

States long ago learned that they cannot afford major coverage expansions if they do not also improve the quality of health care and contain the growth in health care costs. Efforts to address quality, cost, and the demand for health care services are too many to count. Minnesota recently passed landmark legislation to establish a unified, statewide system of quality-based incentive payments and to help consumers and other purchasers compare providers on overall cost and quality of care. Pennsylvania has taken a comprehensive and innovative approach to reducing medical errors. North Carolina is a recognized leader in improving care for Medicaid enrollees with chronically illnesses. Arkansas is celebrated for its innovative approach to reducing childhood obesity. South Dakota has focused on ensuring that the elderly receive oral health care. Vermont's health reform efforts include a state-wide system of care to address chronic conditions.

While ideological differences exist around the country, states have demonstrated that it is possible to find middle ground on health care. They have overcome partisan and stakeholder differences to adopt reforms designed to address the real challenges and problems their residents face. The middle ground generally includes some combination of expanding public programs, subsidizing families and businesses to make insurance coverage more affordable, and demonstrating a real commitment to controlling program and overall system costs. States have eschewed policies at either extreme: avoiding approaches that rely on a single payer approach or that expect unregulated markets to solve the problems of the health care system.

State political leadership and successes have ignited hope across the nation that solutions can be found to problems in our health care system. While many of these problems continue to get worse, it is state experience that allows us to have optimism about the future.

2. **States' ability to address major health care system challenges is limited.**

Despite some successes, the states' ability to address the health care challenges our nation faces is limited. States are constrained for many reasons. They face statutory, market, financial, and structural constraints that will always prevent them from achieving the broad-based, system-wide reforms we need.

States lack the authority to affect many of the health care activities within their borders. About half of a typical state's residents are completely outside the reach of state authority because they are enrolled in Medicare, have coverage through an employer that self-insures, or obtain services through the Department of Veterans Affairs, Indian Health Service, or other programs. Medicare acts independently of state policy in exercising its dominant role as a purchaser of health care services. The Employee Retirement Income Security Act of 1974 (ERISA) preempts state laws that relate to private employer-based health plans. National and multinational insurers, hospital systems, pharmaceutical companies and medical supply companies operate beyond the reach of state legal authority but have a significant effect on health care costs within a state. Although it is possible for states to design reforms that fit within their current authority, these boundaries foreclose a series of options that might be more effective.

States also face important budgetary constraints. Current federal policy is that state reforms must be budget neutral with respect to federal Medicaid and State Children's Health Insurance Program (SCHIP) costs. Expecting states to address the many vexing issues in health policy on their own is unrealistic and severely limits the number of states that can even make such an effort. In addition, unlike the Federal Government, all but one state operates under a balanced budget requirement. Any successful health coverage plan must be able to operate through all phases of the economic cycle—a particular challenge for state-based reforms. This fiscal year, as many as 28 states are reporting budget shortfalls, creating pressure for states to cut services and government spending even as they are seeking opportunities to expand coverage.

3. **Federal Leadership is Needed.**

Given the challenges noted above, we should not be surprised that only three states—Maine, Vermont, and Massachusetts—have adopted comprehensive approaches to health care reform within the last decade. Meanwhile, reform efforts remain stalled in larger states such as California, Illinois, and Pennsylvania. While state efforts make a real contribution, federal leadership is needed to make substantial, sustained progress in health reform efforts.

Federal leadership could take several forms including one that provides a substantial role for states to operate within a national framework. Indeed, approaches that combine the resources, stability and uniformity of federal involvement with the dynamism, local involvement, and creativity of states can foster excellent results. The Federal Government can bring its clout as the largest purchaser, stable funding that can weather economic ups and downs, and standards that can assure all Americans they will have meaningful access to needed health care services. States can design the details of any plan to conform to local market and medical practice conditions, develop various models that enable us to learn what works and what does not, and assure that program operations reflect local values.

A "joint venture" approach between the Federal Government and states would enable states to continue to serve as the laboratories of democracy. But if states are to serve as laboratories, they need to be afforded the resources necessary to achieve the high hopes we have for them. All credible national proposals for health reform come with a price. States cannot pursue comprehensive health reform without substantial and reliable financial participation by the Federal Government. Medicaid provides a solid platform on which states can build, but coverage expansions are generally dependent on waiver negotiations, which are time-limited and subject to much discretion on the part of the Federal Government. Some grand redistributive scheme might theoretically allow for the provision of insurance coverage to everyone for the amount of money already in the health care system; however this is not a realistic approach when limited to a single state.

A serious endeavor to support state efforts would have to build in a long-term financial commitment proportionate to the share of the problem states are expected to address. In addition, a serious state-based effort would need to anticipate the challenge of providing quite variable amounts of money to different states, given the tremendous disparity in the scale of the problem each state faces.

A genuine commitment to having the states function as laboratories would require revitalizing the research and demonstration component of Section 1115 waivers, expanding the commitment to evaluation in all program waivers, and moving away from budget neutrality as the guiding principle of waiver approval. Despite the fact that Medicaid Section 1115 waivers provide states with flexibility for "research and demonstration," these waivers are often granted primarily to enable states to make budget neutral program changes with a very small research component. A commitment to experimentation would include a willingness to spend money on ideas that might yield improvements along a number of dimensions other than short-term program spending, including improving the quality of care patients receive and lessening the likelihood of more expensive interventions.

Federal waivers, while helpful in some instances, are no substitute for a clear federal commitment. Some have suggested that federal reform proposals include "ERISA waivers" that would allow a federal agency or group of federal officials to waive provisions of ERISA on a short-term basis. These waivers are just another form of uncertainty—for businesses and for states—and they grant excessive authority to federal program administrators. By contrast, carefully crafted federal safe harbors—policies that states can adopt that would be defined as permitted under federal law—would provide clear guidance and could be designed to avoid undue burden on multi-state employers while also enabling true state experimentation. For example, states should have the authority to adopt uniform "pay-or-play" strategies to finance broad-based coverage initiatives. States should be able to require self-funded employers to participate in premium assistance programs. And states should be able to mandate participation from all public and private payers in state-wide data collection and system performance improvement projects.

Finally, federal leadership is important as a means to bring down unwarranted variation across the country in health care practice and costs. A recent Commonwealth Fund report describes interstate variation across dimensions such as appropriate use of antibiotics to reduce the risk of infection during surgery and the incidence of deaths amenable to health care.[2] Variations across states in the share of the adult population without health insurance has existed for decades; in 2004–05, these ranged from a high of 35 percent of adults uninsured in Texas to a low of 11 percent of adults uninsured in Minnesota. National requirements, resources, and benchmarks can all serve to close some of these gaps.

By contrast, when states operate entirely on their own, they are likely to yield increased variation in health coverage, access and quality across states. States tend to build on their own successes, pushing the leaders farther ahead and leaving others behind. Diffusion of policy innovations both among states and from states to the

[2] J. Cantor et al., *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, 2007).

Federal Government is slow and sometimes does not occur at all. A desirable reaction to high levels of variation in health care is to set national goals based on best practices. State and national policy efforts can then be focused on raising the bar for everyone and reducing the degree of variation through strategies that bring those farthest behind closer to the front of the pack.

Ultimately, federal leadership matters. Consider the example of adults' and children's health insurance coverage. Compare the change in health coverage status of adults and children in the United States over the past decade. For adults, there is no national strategy. Medicaid, which represents the nation's primary commitment to meeting the health needs of the poor, explicitly excludes non-elderly adults from coverage unless they have a disability or have children living with them. For children, there is a national strategy. Despite some important exceptions and limitations, the combination of Medicaid and SCHIP extends coverage to almost all children living in families with incomes up to twice the federal poverty level. The contrast is stark: between 1999–2000 and 2005–2006, the overall percentage of uninsured adults increased in 43 states while the percentage of uninsured children decreased in 32 states. The combination of a national priority with the resources to support it and state flexibility in the methods for achieving national goals can yield tremendous results.

4. **States Can Be Effective Partners in Meeting Health Care Needs.**

In my job I have the opportunity to speak to a broad array of state health officials. Their message to me is surprisingly consistent regardless of their job title, political affiliation, or state. They are doing what they can to address issues and problems that are bigger than the resources they have to respond. They are eager for federal leadership and they feel its absence. But they are also nervous about a heavy-handed or one-size-fits-all approach.

Recent experience, particularly related to state coverage efforts in Medicaid and SCHIP, has been dispiriting for states. A number of developments at the federal level have disappointed state expectations of funding or frustrated state efforts to move forward with coverage initiatives funded in part with federal funds. The inability of Congress and the President to agree on SCHIP reauthorization presents states with tremendous uncertainty regarding how to finance coverage. The Centers for Medicare and Medicaid Services (CMS) issued a letter on August 17, 2007, without any prior consultation with states, the terms of which undermined a variety of state plans to cover children.[3] New citizenship and identity documentation burdens in Medicaid have increased administrative costs and resulted in the disenrollment of eligible citizens. Additional limitations on available Medicaid funds through regulations and sub-regulatory initiatives have undermined federal support for the most vulnerable populations and shifted burdens to states even as state budgets are tightening.[4] All of these events have served to limit state progress and squelched enthusiasm for federal-state partnerships.

A true, federal solution to our health care problems requires a more cooperative approach between the Federal Government and states—one that respects state investment and provides the tools and resources states need to be an effective partner in achieving health reform goals.

Conclusion

I conclude with the same words I used in the article I wrote on this subject:

"In the absence of federal action, states will lead, and states will accomplish as much as they can, given the constraints they face. But piecemeal state action will not add up to what the nation needs. A national response that honors the history of American federalism would include a series of national commitments that frame and support what states can do—indeed, what they are eager to do."

Chairman STARK. Thank you very much.
Ms. Bigby.

---

[3] See J. McInerney, M. Hensley-Quinn and C. Hess, *The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs* (Washington, DC: National Academy for State Health Policy, April 2008). *http://www.nashp.org/Files/shpbriefing*_cmsdirective.pdf

[4] See S. Schwartz and J. McInerney, *Examining a Major Policy Shift: New Federal Limits on Medicaid Coverage for Children* (Washington, DC: National Academy for State Health Policy, April 2008) *http://www.nashp.org/*_docdisp_page.cfm?LID=C7DE48DC-68F8-46B2-A56741E6A8F6EFEE

Dr. BIGBY. Good morning.
Chairman STARK. Good morning.

STATEMENT OF JUDYANN BIGBY, M.D., MASSACHUSETTS SECRETARY OF HEALTH AND HUMAN SERVICES, BOSTON, MASSACHUSETTS

Dr. BIGBY. I want to thank you, Chairman Stark and Ranking Member Camp, for inviting me to testify before this hearing today on state health care reform. I am JudyAnn Bigby, I am the secretary of health and human services for the Commonwealth of Massachusetts, and I am honored to be here today to represent Massachusetts and Governor Deval Patrick, to tell you about the efforts to reform health care in Massachusetts.

I want to start by telling a very brief story. I have lived in the community that I currently live in for over a decade. I have taken my clothes to the same dry cleaners for that period of time. A few months ago, the woman who is the co-owner, with her husband, of this family business said, "Oh, Dr. Bigby, I saw you on TV doing a PSA on health insurance. And I want to tell you, health reform in Massachusetts is the best thing that could have happened to us."

"We never thought, as a small business, that we could afford to buy insurance for ourselves, but we did. I had my first check-up in 19 years, because of this. And I discovered that my blurred vision was due to cataracts, which I have had fixed, and I can now see again. And thank you for helping to implement this program."

That is the story of one person, but we know that we have hundreds of thousands of people in Massachusetts who are now covered because of heath care reform.

From the beginning, the strength of this effort in Massachusetts was marked by a coalition of people that represent representatives from the executive and legislative branches of government, providers, insurers, employers, consumers, advocates, and community leaders. In April of 2006, you all know that Massachusetts enacted a health care reform bill that was designed to move the state to near universal coverage.

The components of this bill allowed us to do several things that are key to the success that we are seeing: number one, expansion of Medicaid, so that we could cover more people; number two, the creation of the Commonwealth Connector, to develop Commonwealth Care, which is a state-subsidized program for low-income individuals who are not eligible for Medicaid; and also, the Connector developed affordable health insurance products for those with incomes over 300 percent of Federal poverty level who did not have access to employer-sponsored insurance.

We also transformed the uncompensated care pool, which is a pool the state had developed more than 20 years ago to pay hospitals and health centers for care for those who were uninsured. We also reformed the insurance market to combine the non-group and small group market, and created the individual mandate, which went into effect in July of 2007, and was enforced as of December 31, 2007. And we also defined what employer responsibility was, through the fair share.

A Medicaid waiver from the Centers for Medicare and Medicaid Services is a critical component of Massachusetts's health care re-

form. This partnership with the Federal Government allowed for expanded Medicaid coverage, including children with families of incomes up to 300 percent of the Federal poverty level. It also eliminated enrollment caps for other individuals so that they could be covered by Medicaid, including disabled working adults and individuals with HIV/AIDS.

We currently are operating under a short-term waiver extension, while we finalize negotiations with CMS for renewal of our waiver. And we look forward to being able to continue this historic effort.

Enhanced employer responsibility requires that all of employers with 10 employees or more contribute a fair share toward covering their employees. We have learned from this experience that defining what a fair share is, is difficult to do. As I said, we have over 340,000 individuals who are now covered who were not covered in June of 2006. More than 170,000 people are enrolled in the subsidized state program at a growth and number that was higher than we expected, due to our underestimate of the number of uninsured in Massachusetts.

But we do know that, since enactment of heath care reform, we have decreased the number of uninsured in Massachusetts by more than half, and we have not seen a decrease in employer-sponsored insurance.

We also know that people are getting access to care, they are going for preventative care, they are reporting that they have regular providers. They also report that their out-of-pocket medical expenses have gone down. We have also seen that the reform of the non-group market has created products with lower premiums and better coverage.

So, we are in a good position to continue this experiment, going forward. What we need is the ability to continue to learn from this experiment, and refine our products, and to engage in our partnership with the Federal Government with as much flexibility as possible. Thank you.

[The prepared statement of Dr. Bigby follows:]

Statement of The Honorable JudyAnn Bigby, M.D., Massachusetts Secretary of Health and Human Services, Boston, Massachusetts

My name is Dr. JudyAnn Bigby, and I serve as Secretary of Health and Human Services for the Commonwealth of Massachusetts. I am honored to be here with you today to represent Massachusetts and Governor Deval Patrick in offering testimony before the House Ways and Means Subcommittee on Health about Massachusetts' historic health care reform initiative.

I particularly want to thank Chairman Pete Stark of California for inviting me to testify today and for holding a hearing on states' health care reform efforts. I also want to thank the other distinguished committee members for their interest in and commitment to this important topic. I look forward to sharing Massachusetts' health care reform experiences with you, and I also look forward to hearing your insights and perspectives.

Massachusetts is proud to be leading the way toward near-universal coverage and working to ensure that everyone has access to high-quality, affordable health care.

From the very beginning, the strength of health care reform in Massachusetts was the support of a broad and diverse coalition, including representatives from across sectors and across the political aisle. Coalition members included representatives from the executive and legislative branches of both federal and state government; providers; insurers; employers; consumer advocates; and community leaders.

In April 2006, Massachusetts enacted a health care reform bill designed to move the state to near-universal coverage. At the heart of this initiative was the principle of shared responsibility among individuals, employers and government. The coalition took steps to achieve near-universal coverage through:

- Medicaid expansions
- The creation of the Commonwealth Connector to develop:
- Commonwealth Care, a subsidized insurance product for low-income individuals not eligible for Medicaid; and
- Affordable health insurance products for those without access to employer-sponsored insurance and incomes over 300% FPL
- Transformation of the Uncompensated Care Pool, a fund developed in Massachusetts more than 20 years ago to pay for uncompensated care in hospitals and health centers
- Insurance reform
- An individual mandate
- Employer responsibility through a fair share and free rider assessment.

A Medicaid waiver from the Centers for Medicare and Medicaid Services is a critical component of Massachusetts' health care reform initiative. Our partnership with the Federal Government allowed for expanded Medicaid coverage, including to children with family incomes up to 300% of the Federal Poverty Line (FPL). The elimination of enrollment caps for Medicaid coverage for several populations—including long-term unemployed adults; disabled working adults; and individuals with HIV/AIDS—also expanded coverage.

We are currently operating under a short-term waiver extension, while we finalize negotiations with CMS for a new waiver. Extending this state and federal partnership is critical to our historic effort to reach near universal health insurance coverage. We are working closely with CMS to come to an agreement that will facilitate the long-term success of health care reform in Massachusetts.

Enhanced employer responsibility requires that all employers with more than 10 employees offer access to pre-tax health plans. Health care reform requires these employers to make "fair share" contributions toward their employees' insurance or be subject to an assessment fee that is used to help cover the uninsured.

In addition, health care reform mandates that adults have insurance unless they do not have access to affordable insurance. The Commonwealth Connector developed subsidized and non-subsidized health insurance products, but also defines minimal creditable coverage and affordability standards.

Health insurance market reforms also merged the small and non-group markets in an effort to reduce the cost of non-group premiums.

We are seeing the positive results of Massachusetts' comprehensive health care reform efforts. Since June 2006, approximately 340,000 individuals now have enrolled in health insurance programs. Enrollment in the state's Medicaid program has expanded by more than 60,000. More than 170,000 have enrolled in Commonwealth Care, the state's subsidized plan for low-income residents. More than 120,000 of them have enrolled in private insurance plans, and the percentage of employers offering health insurance has increased from 68% to 72%, while the percentage has been dropping nationally.

We are seeing the impact.

A recent Urban Institute survey of Massachusetts residents showed that the adult uninsured rate has decreased by 50% in just one year. Low-income adults, men and young people have seen the biggest drops in rates of uninsurance.

In addition, more people report having access to a regular health care provider and have made visits for preventative care. The percentage of adults who reported that they did not access care due to costs have decreased, and individuals report lower out-of-pocket medical costs.

The percentage of adults who have employer sponsored insurance has increased slightly.

Premiums for non-group insurance have decreased while the benefit package has improved.

Between FY06 and FY07, visits billed to the Uncompensated Care Pool (now the Health Safety Net) decreased by 15%. The cost of care funded declined by 9% during the same period. We are projecting it will fall significantly more in the current fiscal year.

We know, however, that providing health insurance is not enough. We are also focusing on controlling health care costs to ensure that the gains we have made in expanding access are sustainable. We will be most successful if we can achieve the most value for the dollars we are spending and do a better job of decreasing costs among the 10% of patients who consume 60 to 70% of the health care dollars.

We need to focus more on prevention, ensuring that individuals have a medical home, and coordinate the care that those with chronic illness receive across the system. The issue of whether we have the primary care capacity to meet the increasing demand of the insured is an important question—not just because we do not want

people to be frustrated by not being able to get an appointment with a primary care provider once they are newly insured, but also because we know that communities and populations are healthier when they have access to primary care. In addition, care is less expensive when the ratio of primary care to specialists is higher than what we currently have in Massachusetts.

To build on the 2006 health care reform efforts in Massachusetts, the Patrick Administration launched the "Healthy Mass" initiative in December. Nine diverse agencies from across state government—in their roles as employers, purchasers, providers, regulators, insurers, administrators, stewards of public health, and potential sources of health care financing—committed to working closely together to ensure access to care; contain health care costs; advance health care quality; promote individual wellness; develop healthy communities.

In these early stages, we are working together to decrease administrative burdens on providers; adopt strategies to improve quality of care; focus on decreasing the impacts of chronic disease; and align payments tosupport primary care and community hospitals.

As part of this initiative, the state announced last month that state agencies, including Medicaid, will no longer pay for costs associated with the 28 serious adverse health care events identified by the National Quality Forum. The state will also no longer permit their providers to bill members for these services. This new policy makes Massachusetts the first state in the nation to establish a uniform non-payment policy across state government. This policy will not only save taxpayer dollars, it focuses attention on strengthening health care quality.

Massachusetts has come an impressive distance in a very short period of time, and we are committed to ensuring not only that people are insured, but that theyalso have access to quality, affordable care and the tools to lead healthier lives. Moving forward, we must share in making thoughtful choices to ensure its continued success.

Thank you.

Chairman STARK. Thank you.

Dr. Lewin.

STATEMENT OF JOHN C. LEWIN, M.D., CHIEF EXECUTIVE OFFICER, AMERICAN COLLEGE OF CARDIOLOGY

Dr. LEWIN. Thank you. It is an honor to be here, Chairman Stark, and Ranking Member Camp. I am pleased to see the rest of you here: Mr. Johnson, Ms. Schwartz, Mr. McDermott, and good friend, Mike Thompson. Thank you all for having this hearing today.

I have been the CEO of the American College of Cardiology for the past 2 years. Before that, I was in California, as the CEO of the California Medical Association. Prior to that, I had been a practicing physician for a long time in Hawaii, and I was the commissioner of health in Hawaii for 8 years at a critical time, when Hawaii was developing and implementing its employer-based access. I wanted to talk a little bit about that.

Hawaii actually passed a law requiring every employed person to have coverage and strongly incentivizing their dependants to be covered, as well, along the Richard Nixon proposal 1974. They thought it was going to become national law. It went through all sorts of court challenges raised by employers, and made it to the Supreme Court, where the law was repealed, actually, on the basis of a violation of ERISA. It took almost 10 years.

Hawaii came, then, to Congress and got an exemption from ERISA to allow the law to proceed. And I had the privilege of implementing much of that coverage. Every employed person in Hawaii, even today, has coverage. All the dependants don't, because

the cost split between the employer and employee wasn't really fixed in the law. And as the costs have gone up, employees haven't been able to afford to pay their percentage of the dependant coverage. So there has been some erosion there.

But Hawaii has done something that is very elegant, basically, in the private sector. It is private coverage. There is a great deal of portability. It was really just requiring that there be a cost split between the employer and the employee.

Now, that—in the waiver that Congress gave to Hawaii—the waiver froze the cost split at the percentage that, at the time, was the average cost of health insurance for employees. And in the early eighties, it was about 3 percent of wages, or salary, across the whole population, that constituted the cost of health insurance for the employee. So, in the waiver that you granted, the employer can't tax the employee more than one-and-a-half percentage of wage.

Now, obviously, that doesn't work today. Hawaii would be afraid to come back and ask for a, you know, a revision of that waiver, for fear that the whole law would be repealed. So the cost shift to the employer, over time, has been fairly significant. But the basic idea was to be a 50/50 split, with some subsidy for low-income workers.

The state also developed a special program of state subsidies for people who were unemployed, self-employed, part-time employed. That program kind of ran out of steam when the state's budget issues came up later.

At one time, Hawaii had 96 percent of its public covered, almost 97 percent. It is now back to 90 percent. It was 96 to 97 percent. Now it is down to 90, yes.

And then, in California, I worked on a variety of efforts, but Governor Gray Davis signed into law SB–2, which was a Hawaii model for employers, but it exempted businesses with under 50 employees. But it was a step, a big step, in California that was passed. It was through the CMA and AFL–CIO, a partnership.

Governor Schwarzenegger, coming into office, led a campaign to repeal that law, successfully, although it was only a 50.5 percent vote. Very, very close. And then he attempted to try to create another system, which I worked with him on. And, as you know, that did not make it through the legislature.

I guess what I would like to share with you is that state reforms are important, they are worthy of respect. They do teach us what works and what doesn't work. But we need national reform, or we will see erosion of even the best state efforts, over time. We need national minimum requirements and policies.

Second thing I would like to share is that an employer mandate has really been kind of disparaged a lot lately as something that we're probably not going to use any more, there has been an erosion of coverage. But employer coverage, if we fix some of the problems of employer coverage, it still is the main source of coverage for most Americans. I don't think we ought to throw it out.

If we made employer coverage more portable, if we fixed some of the fair insurance practice issues that would make it better, if we expanded choice of coverage with employer coverage, maybe through regional or state purchasing cooperatives like the FEHBP,

then employer coverage, for those who have it now, would be stabilized in the future, as we try to expand coverage for people in agriculture and food services and retail and small businesses that don't have coverage today.

I think the other points I would make is that the reforms in California, the reforms in Hawaii that I was privileged to participate in, really didn't focus on quality of care improvement, and on systematically improving quality and patient safety. Any kind of Federal action would need to incorporate that, as well as electronic, you know, EMRs, personal health records, inter-operability standards that would great facilitate improvement in quality and reduce administrative costs.

And, finally, we have very perverse payments, even, obviously, through Medicare that don't really reward quality or patient safety. And we would love to work with you, here in Congress, to actually change those payment processes so that they do, in fact, incentivize quality and improvement.

The current system, unchanged, is going to be a financial train wreck. It is going to be both an economic and ethical imperative to change it. States will continue to serve as critical laboratories. But we need Federal action, and we need Federal commitment and national policy to guarantee that everyone will have coverage in the future. And we look forward to working with you to achieve that. Thank you.

[The prepared statement of Dr. Lewin follows:]

Statement of Jack Lewin, M.D., Chief Executive Officer, American College of Cardiology

Statement for the Record of the Hearing of the
House Ways and Means Committee
Subcommittee on Health
On
"State Coverage Initiatives: Lessons For the Nation"

Testimony of John C. Lewin, CEO, American College of Cardiology
Former Director of Health in Hawaii
Former CEO, California Medical Association

On
Lessons Learned from Advancing State-Based
Access to Care Reforms in Hawaii and California

July 15, 2008

As CEO of the 36,000 member American College of Cardiology here in Washington, DC, I am honored to have the opportunity to testify to the Subcommittee today on a most important health policy topic — the pressing need to advance access to care in this nation. The perspectives I share and lessons gleaned from them are based on my previous direct career experience in advancing state-based access to care reforms in both Hawaii and California.

I was Director of Health in Hawaii from late 1985 until late 1994, serving as a member of the governor's cabinet and overseeing 6,500 employees and a $1 billion statewide health department and hospital system. As such, I oversaw much of the implementation of Hawaii's universal employer health insurance mandate, and also designed and implemented the supplemental State Health Insurance Plan (SHIP). The state subsidized SHIP program successfully covered the vast majority of remaining uninsured persons who were unemployed, self-employed, part-time employed, or otherwise ineligible for employer coverage.

The landmark Hawaii Prepaid Health Care Act actually passed the legislature in 1974, modeled after what the young state presumed would be the national access to care policy model fostered by then-President Richard Nixon. Interestingly, ERISA, which strictly limited state actions of this kind, was passed by Congress just a few months after Hawaii's legislature acted. The new Hawaiian law required health coverage for ALL employed persons working more than 19 hours per week, with benefits approximating the prevailing average employer plan coverage in the state. HMSA (the statewide Blue Cross and Blue Shield plan in Hawaii) and Kaiser Permanente dominated health insurance coverage in the state, which gave the plan a high degree of portability with job changes. The Prepaid Health Care Act's goal was to require a 50-50 cost split between the employer and the employee overall, based on estimates at the time that an employee's health insurance globally averaged about 3% of wages or salary. The employee's required contribution was not therefore to exceed 1.5% of wages, which targeted the 50-

50 split of premium goal, and also ensured lower income employees could afford their share of the costs.

While billed as an "employer mandate," this law was actually also an employee mandate. The employer share for low income or minimum wage employees was understood to be greater than 50% of costs, but for the majority of workers whose wages exceeded about $50,000, the split approximated 50-50. Public employee unions negotiated a special cost split provision in the law for their beneficiaries of 60% employer/ 40% employee. No businesses were exempted, including those with only one employee. The law required that dependents be offered the same guaranteed coverage, but the employer-employee cost split for family coverage was not specified — in practice, the 50-50 cost split was typical there as well. Unemployed, self-employed, and part-time under 19 hours-per-week persons were not covered. The law did not cover medications, dental, institutional mental health, or long-term care benefits, but had generous outpatient, inpatient, emergency room, laboratory and diagnostic services coverage through private health insurers (basically HMSA and Kaiser Permanente). There were no real cost-cutting or quality of care provisions in these programs.

Once passed, while many employers voluntarily implemented the law, the Prepaid Health Care Act faced a decade of legal challenges from employers extending all the way into the early 1980s, culminating in a Supreme Court decision that it violated ERISA and could not be implemented. Hawaii then proceeded to Congress to get a narrowly-passed, controversial exemption from ERISA to implement the law. A major problem with this solution was that the law could not be amended as costs increased and the environment changed: the provisions in the law that made sense in the 1970s and early 1980s were frozen without returning to Congress for amendments, and returning to Congress could easily have resulted in an unintended consequence of eliminating the exemption and the law altogether! As a result, it has never been amended, and a number of factors have weakened the law's acceptability over time:

- As costs have increased and the average cost of health insurance far exceeds 3% of wages or salary, the 1.5% maximum deduction for the employee has shifted most of the costs onto the employer;
- Rising costs have made some employers shift much more than 50% of family coverage costs onto the employee — and some employees feel they cannot afford even 50% of the family premium — putting dependent coverage at risk;
- While an increase in part-time employment (to avoid coverage costs) was not a problem for the first 20 years of implementation, it appears to be increasing now as costs continue to escalate in Hawaii as everywhere else.
- The basic benefits program for the unemployed and self employed — the SHIP — was folded into a Medicaid waiver in 1995, which caused the premiums to triple with the required additional Medicaid benefits. Many of the beneficiaries could no longer afford their share of the premiums and dis-enrolled. In addition, the changed enrollment processes proved much more cumbersome for many of

> these beneficiaries. The resulting reductions in coverage further taxed the Prepaid Health Care Act by the cost-shifting associated with having the previously insured SHIP beneficiaries return to the ranks of the uninsured, and to emergency rooms for primary care.

Hawaii's achievements with the full implementation of the Prepaid Health Care Act, and later with the addition of the state-subsidized supplemental SHIP program, were stunning. By 1990, Hawaii had achieved near-universal coverage of approximately 96% of the population. It also had in place an excellent safety net and system of community clinics to address the needs of homeless, mentally ill, non-citizens, and other "uninsurable" persons and those with special health needs.

But, because there has been no parallel federal access to care action, because of rising costs, and because we had no ability to modify the Prepaid Health Care Act, these accomplishments have eroded. In 2007, according to the US Census Bureau, Hawaii had dropped to covering less 91% of the population. While every full-time worker in Hawaii still has coverage — and that is no small thing — increasing numbers of dependents are not covered. The unemployed, self-employed, and part-time employed have the same difficulties getting coverage now as anywhere else in America. Hawaii's accomplishments will further unravel in the absence of national reforms.

I was also the CEO of the California Medical Association from 1995 through 2006 until moving to Washington to assume the role of CEO of the ACC. California has more than 7 million uninsured persons, in addition to perhaps 3 million undocumented residents without coverage. While in California, the CMA led multiple legislative efforts to pass access to care reform legislation. Working with AFL-CIO, in 2002 we proposed an auspicious bill, SB2, roughly based on Hawaii's Prepaid Health Care Act, which was passed by the Legislature and signed into law by then Governor Gray Davis. SB2 exempted businesses with less than 50 employees (a significant compromise), and had a fixed 80%-20% split in premium costs between employers and employees. The bill was to be implemented through competition of private insurers. The thought was to incrementally bring in smaller businesses over time after the bill passed. Public polls showed considerable support for SB2, but before its actual implementation the new Governor Arnold Schwarzenegger led an effort to repeal it through a public ballot initiative, which subsequently passed by a very narrow margin of 50.5%. The arguments against SB2 were fear tactics, designed to convince insured persons that if it passed, their own employer coverage would be destabilized toward a government system, which was clearly antithetical to the intent of SB2.

Following the repeal of SB2 we then worked with Governor Schwarzenegger to attempt to craft a new proposal that considered state-subsidized individual coverage for uninsured workers. This proposal, despite its attempt to avoid employer opposition, failed to pass the legislature.

In summary, there are several lessons learned through these noble experiments at the state level in California and Hawaii that pertain to the agendas before Congress now:

1. State access to care reforms are important and worthy of national support. They have covered more people and have provided lawmakers information on what works, and as importantly what does not work. However, these initiatives are unstable for a number of reasons, such as state budgets. **We need national access to care minimum requirements and policies to ensure that all Americans have coverage that is transportable and consistent across states**. States may still play important roles in a necessary national strategy.

2. Employer coverage, while measurably in apparent gradual decline in America, still affords numerous advantages in efficiently covering most employed Americans, and in possessing administrative advantages in the collection and management of premiums. That acknowledged, employer coverage very often offers little or no choice of plan options, is too often based on inefficient and sometimes unethical experience rating of beneficiaries, and is not portable from job to job. Rather than taking the fiscal risks of shifting what is currently private to public health insurance by phasing out employer coverage as some pundits suggest, we should explore improving employer coverage by promoting state or regional insurance collaboratives that function like the FEHBP to enable the benefits of portability, community rating, and expanded employee choice of coverage options to employer coverage that lacks such attributes today. As we expand access to care for the currently uninsured, let's also preserve coverage that works fairly well for the majority of Americans who have employer-based insurance before we move to a universally different system that is yet untested.

3. Measurable and transparently reportable evidence of quality improvement and cost effectiveness, based on valid data and science-based practices, have not yet been central priorities in the state-based access to care reforms implemented thus far. They have done a lot of "putting together commissions" with little action. Improving quality and patient outcomes must be central to all future efforts if they are to succeed.

4. While neither California's nor Hawaii's efforts in access to care reform focused on electronic or e-health innovation, any state or national effort needs to strongly incentivize electronic medical records, e-prescribing, and quality of care registries that measure quality of care based on established scientific guidelines, performance measures, and appropriate uses of technology. However, standards for inoperability must be national to be effective.

5. Finally, any serous reform effort must realign the perverse incentives of the current payment systems for doctors, health professionals, hospitals, and insurers to instead promote quality, cost-effectiveness, prevention, and patient-centered outcomes improvements.

References

1. *Health Affairs* (Lewin, JC and Sybinsky, PA). Implications of National Health Expenditure Estimates on State Policy: Concerns from a Small State, Vol. 13, Winter 1994.

2. *American Journal of Surgery,* Reflections on National Health Care Reform Based on Hawaii's Experience, February 1994.

3. *Journal of American Medical Association* (Lewin, JC and Sybinsky, PA), Hawaii's Employer Mandate and its Contribution to Universal Access, Vol. 269, No. 19, May 19, 1993.

4. The United States Congress, *Hearing before the Committee on Finance,* S.3180 B The State Health Care Act of 1992, September 9, 1992.

5. *Business and Health,* A Blueprint for Health Care Reform, mid-September 1992.

6. Chapter in: Brecher, C. ed., *Implementation Issues and National Health Care Reform,* Macy Foundation, The Implementation of Health Care Reform: Lessons from Hawaii. New York City: Josiah Macy Jr. Foundation, June 1992.

7. *Journal of Health Care Benefits,* Health Care in the State of Hawaii, May/June 1992.

Chairman STARK. Thank you very much. And, Ms. Riley, how are things in the great state of Maine?

Ms. RILEY. They are fine, Chairman Stark, and I am pleased to report that Governor Baldacci was reelected.

STATEMENT OF TRISH RILEY, DIRECTOR, MAINE GOVERNOR'S OFFICE OF HEALTH POLICY AND FINANCE, AUGUSTA, MAINE

Ms. RILEY. Thank you very much for the opportunity to be here, Chairman Stark, Ranking Member Camp, and Members of the Committee.

You asked us to speak a little bit about the lessons learned in the past 5 years. And maybe the most important lesson, following Jack Lewin, is that states have been at this work since 1970. And each decade saw new kinds of reforms. We, in Maine, were pleased to start the fourth wave of state health reform in 2003, with the establishment of our Dirigo health reform.

Absent any sustainable new sources of revenue, Governor Baldacci sought to achieve health reform by improving the efficiency of the health care system to achieve savings and reinvest them in health care access.

We learned early that clear goals are important. Covering the uninsured implies that we will find adequate financing to bring those now without coverage into the insured tent. Such an approach generally accepts the status quo in how care is delivered and coverage provided. The goal which was ours, to assure every man, woman, and child has access to affordable, quality care, is different. It seeks health security for all, those without coverage, those with inadequate coverage, and those who fear rising costs will jeopardize their coverage.

Numerous studies that you well know have documented that we, in the United States, pay for redundancy, inefficiency, variation, and over-supply. A recent McKinsey Global Institute study concludes that we spend $477 billion more on health care than peer nations, yet, as you well, know, we don't cover everyone, and we don't get better outcomes or health or quality for that investment.

When Dirigo began in 2003, Maine had the highest rate of uninsured in New England. By 2006, every state in New England saw their uninsured rates rise. Only Maine saw that rate drop, and drop to the lowest in the region. But our progress has been stalled, lacking adequate finances. And I think this will be the last time I say this, given Secretary Bigby's response, because I am certain Massachusetts has now outpaced us, and I congratulate them for that.

To guide Maine's reform, we convened stakeholders in a health action team. We found earlier that process may be as important as policy in this effort of health reform. The legislature created a special joint commission on health reform, with members from the health, insurance, and appropriations Committee convened together. The reform debate played out largely between two camps: those who wanted deregulation and market-based solutions, and those who wanted more investment to sustain comprehensive coverage to cover all the uninsured.

Long negotiations resulted in significant amendments to the original bill, and found a middle ground that won strong bipartisan

support. Both the health action team and the Joint Committee were dissolved, once the bill was enacted.

In hindsight, with oversight of the reform split among different legislative Committees, and no one single stakeholder group to provide guidance to the overall reform, a vacuum was created that allowed the parties to return to their corners when the inevitable implementation challenges occurred. Enacting health reform, we have found, is tough. Few states have done it. But implementing reform is tougher. And I think whenever we think about how to frame a Federal response, we have to think about the long-term implementation.

To achieve progress, all parties with strong leadership need to stick to it, and work together to make mid-course corrections, rather than see each bump in the road as an opportunity to defeat reform.

As Alan Weil pointed out, Medicaid is a critical component of any kind of reform, and we based our reform on it, as well. Since delinking welfare and Medicaid eligibility, and imposing work requirements, more low-wage and part-time workers receive Medicaid because they can't receive or can't afford workplace coverage. The premium assistant provisions within the Medicaid program need serious reform. They are difficult to administer, pay only for the employee's share of the premium, and require a state match.

The Dirigo health reform sought to pool all revenues, including employer contributions from our small businesses who are covered, and used those pooled state resources to match Medicaid for eligible employees and their dependants. CMS rejected our approach, which will soon be tested in the courts.

There are several other ways that the Federal Government could take action. Complexity and redundancy are costs in the system. Streamlining and creating a single system—and that does not necessarily mean a single payer—would help. The Federal Government should examine its considerable purchasing power to its standardizing reporting, payment policy, benefits, eligibility, and quality metrics.

Secondly, if states are to play a role in health care reform, they need the capacity to work in a level playing field, and ERISA now prohibits that. It prohibits much creative work, and even the collection of key data from self-insured businesses, and needs to be amended.

I think it is particularly important that we have Jack Lewin here, from Hawaii, because it reminds us that states have been at this work for over 30 years. For 30 years, states have been the laboratories of democracy, adopting insurance reforms before HIPAA, starting children's health programs before SCHIP.

While states have done extraordinary work to lay the foundation for reform, each state is operating relatively independently, based on very different health systems, coverage, and costs, and reflecting different state priorities. That state-to-state variation results in fragmentation and complexity across the country, which drives costs.

Over three decades of state health reform, and the reams of studies and evaluations analyzing them, suggests to me that it is time to get out of the laboratory and learn from the decades of state ex-

perimentation. We cannot reform our health system piecemeal, or even by further state-to-state innovation. In the spirit of Federalism, the national government must commit to a national policy and a clear road map that achieves affordable, quality health care for all, and finally answers the question: Who pays?

Thank you very much.

[The prepared statement of Ms. Riley follows:]

Statement of Trish Riley, Director, Maine Governor's Office of Health Policy and Finance, Augusta, Maine

Thank you for this opportunity to talk with you about lessons learned at the state level about health care reform. Perhaps the most important lesson about state health reform is that it comes in waves, each building on the lessons of the past and learning from the challenges states find in building sustainable health reform over time. But each wave ultimately collides with the critical question—who pays?

I have been fortunate to have been directly involved in many of these efforts as a former Medicaid director and to have worked closely with the reforming states in my service over the past several decades with the National Academy for State Health Policy. Enactment of Medicaid in the 1960s was arguably the beginning of state health reform, although the initial wave of state *initiated* reform began in the 1970s when Hawaii enacted the first mandate requiring most employers to offer health coverage, advanced soon after President Nixon's health reform—that included a similar provision—had failed. In the decade of the 1970s the first high risk pools were created. In the 1980s Washington State established the subsidized Basic Health Plan, Massachusetts enacted the Health Security Act and Oregon created the Oregon Health Plan. Children's health plans began in Minnesota and Vermont.

By the early 1990's 46 states had adopted insurance reforms, children's health programs grew in other states and Medicaid waivers yielded Arizona Access, TennCare and RiteCare, Medicaid managed care based programs to expand coverage. Each of these initiatives had their advocates and detractors, some failed, some changed, most held on in some form but following the failure of the Clinton health plan in the early 1990's state action again stalled and states were in the ebb of a third wave of reform.

In 2003, Maine led the fourth wave with the establishment of our Dirigo Health Reform. Our approach was comprehensive health system reform, focusing on affordability and driven by Maine's per capita health spending, which ranks the second highest in the U.S.,by then the highest rates of uninsured in New England, decline in employer sponsored plans and by limits in state budget capacity. In 2002 state and local revenues in the United States had the slowest growth since records were kept. Absent any sustainable, new sources of revenue, Governor Baldacci sought to achieve health reform by improving the efficiency and effectiveness of the health care system. By improving the system's efficiency, savings would be created and reinvested in health care access.

Clear goals are important: "Covering the Uninsured" is not the same goal as "making sure every man, woman, and child has access to affordable, quality care".

Covering the uninsured generally implies that we will find adequate financing to bring those now without coverage into the insured tent—covered through one or more of the myriad of coverage options available today or by creating special plans for the uninsured. Such an approach generally accepts the status quo in how care is delivered and coverage provided. But with growing pressure on the affordability of our employer based system, more costs are shifted to employees andcoverage can become less comprehensive. As a growing number ofpeople use more of their incomes for sometimes less coverage, more people are *under* insured—forestalling needed care for fear of incurring out of pocket costs they cannot afford. And the literature is filled with data documenting concerns with quality of care. Our goal of assuring every man woman and child has access to affordable; quality care seeks to provide health security for all—those without coverage; those with inadequate coverage and those who fear rising costs will jeopardize their coverage.

Numerous studies have documented that the U.S. spends far more than other developed nations yet we leave 47 million uninsured and do not achieve better health outcomes or quality for that additional investment. In fact, we pay for redundancy, inefficiency, variation and oversupply. Recently, McKinsey Global Institute published "Accounting for the Cost of Health Care in the United States" that concludes

that even after adjusting for its higher per capita income levels, the United States spends some $477 billion more on health care than peer countries.

McKinsey notes that higher health spending in the U.S. is not explained by higher disease burden but by these factors:

1. Higher input costs—salaries, drugs, devices and profits, (e.g.: we use 20% fewer drugs yet pay 50–70% more for them and we are the largest consumers of medical devices in the world).
2. Inefficiencies and complexity in the system's operational processes (eg: we have 3–6 more scanners than Germany, UK, France and Canada).
3. Costs of administration, regulation and intermediation of the system.

McKinsey's study reinforces Maine's approach to comprehensive, system reform, stating "most components of the U.S. health care system are economically distorted and no single factor is either the cause or the silver bullet for reform".[1] While it is unlikely that Americans, who value choice, will adopt all the provisions that make other countries' health care more affordable, unless Americans are ready to embrace higher costs and a greater investment of our GDP in health, then the cost issues must be addressed head on.

In crafting the Dirigo Health Reform, Maine's strategy was to affect cost, quality and access together, reflecting our conclusion that we had an inefficient health care system which led to unaffordability of health insurance and a growing number of people who were under- and uninsured.

We built the program by expanding Medicaid for the poorest of our citizens, establishing a subsidy program for those just beyond Medicaid eligibility; launching comprehensive activities to improve health and reduce the costly burden of chronic disease; creating the Maine Quality Forum to remediate costly variation in the system; initiating a variety of cost containment mechanisms; requiring medical loss ratios in the small and non-group markets; increasing transparency through price posting and standardized reporting by insurers and hospitals; supporting electronic medical record diffusion; strengthening certificate of need; establishing a capital investment fund as an annual budget for new capital investment and facilitating collaboration among providers.

Our cost containment goal is to assure coverage remains affordable for those who buy it privately but subsidizing health coverage remains a tool to meet the affordability gap for those with lower incomes. The foundation of Maine's coverage expansion was Medicaid. From that base we built a sliding scale subsidized insurance plan, DirigoChoice, targeted to those 3 times the poverty level who were employed in small businesses with fewer than 50 emplyees,were sole proprietors or individuals—categories that include the majority of uninsured—and built the reform on the employer based system. Specifically, the plan pooled small businesses to achieve economies of scale and purchasing power and adopted medical loss ratios in the small group and individual market to help make those markets more affordable. DirigoChoice is a voluntary program, recognizing that unless and until insurance became more affordable, mandates would not be tolerated. The program is financed through an assessment on insurers and those who administer self—insured plans that can only be levied if Dirigo's comprehensive reforms result in documented savings

When the Dirigo Health Reform began in 2003, Maine had the highest rate of uninsured in New England. In the years following, as Medicaid expansions took hold and DirigoChoice became the fastest growing product in the marketplace, every New England state saw its rate of uninsured increase; only Maine saw its rate fall to the lowest in the region by 2006.

But our progress has stalled, lacking adequate financing. While $110 million in savings has been independently documented since the program began, those savings have been contentious, subject to court challenge and highlight the complexity of cost containment in health care. Payers of the surcharge assert that reducing the rate of growth of health care costs is not the same as cost savings. The Legislature enacted alternative financing this session, including taxes on beer, wine and sugared beverages, but this alternative is also being challenged.

Politics Trumps Policy—The process of enacting and implementing reform is as important as the reform.

To launch Maine's reform, stakeholders were convened in a Health Action Team that met often and in public to guide the Governor's office in developing the original

[1] McKinsey & Company, *Accounting for the Cost of Health Care in the United States, January 2007*; p. 19.

proposal. The Legislature created a Special Joint Committee on Health Reform with bipartisan members from the health, insurance and appropriation committees.

The reform debate played out largely between two camps—those who wanted deregulation and market based solutions like high risk pools, arguing that lower costs would assure more coverage and others who wanted more investment to sustain comprehensive coverage to cover all the uninsured. Long negotiations resulted in significant amendments to the original bill and found a middle ground that won a unanimous committee report and strong bi-partisan support in both chambers.

Both the Health Action Team and the Joint Committee were dissolved once the bill was enacted. Numerous commissions, workgroups and an independent Board of Trustees for the Dirigo Health Agency assured citizen input throughout the implementation of the reform, but each group was responsible for a part of the reform only. In hindsight, with oversight of the reform split among different legislative committees and no one single stakeholder group to provide guidance for the overall reform, a vacuum was created that allowed the parties to "return to their corners" when the inevitable implementation challenges occurred. Amendments to the original bill, that eliminated a planned global budget and a fixed assessment that could not be passed on to premium payers, reduced the ability to generate stable, predictable funding and attain the amount of cost savings initially envisioned. As the program was launched, additional revisions were required that further challenged the ability to meet enrollment target timetables developed with the original legislation and never revised. Rather than recognize that these unexpected factors would slow but not deter program enrollment, proponents of alternative strategies quickly declared Dirigo a failure and revived advocacy for their favored market based reforms, which created a challenging environment for program modification and mid-course improvements.

As Maine's experience clearly shows, enacting health reform is tough enough—few states have done so—but implementing reform is even tougher. The devil is indeed in the details and health reform is a work in progress. But to achieve that progress, all parties, with strong leadership, need to commit to it and to work together to make mid course corrections rather than to see each bump in the road as an opportunity to defeat reform.

Medicaid is a critical component for state-based reform but needs reliable, counter cyclical financing and clarity in its coverage for eligible, employed beneficiaries.

Should national health reform maintain the current employer based system, Medicaid's role will remain critical. Medicaid is the essential building block in state health reform and is of paramount concern to the states and to Congress. As states face recessions and budget challenges, Medicaid's funding formula needs to keep pace with rising costs and demand.

Since de-linking welfare and Medicaid eligibility and imposing work requirements, an increasing number of low wage and particularly part-time workers, work each day in firms large and small, and qualify for Medicaid—often ineligible for or unable to afford workplace coverage. The premium assistance provisions within the Medicaid program are difficult to administer, pay only for employee share of premium and require state match. Additional policy debate needs to address where the role of the Medicaid program ends and the role of the private employer begins. As costs escalate, private employers are increasingly reluctant to offer coverage to part-time workers and to make Medicaid eligible employees part of their workplace health plan. On the one hand, employers face difficult trade offs as the costs of health care grows. Increasingly employer—based coverage has passed more and more cost on to employees. As lower wage employees pay a larger part of their incomes for health care, we are witnessing a new and growing problem of underinsurance. But employers must balance the costs of health care against the ability to create jobs or increase wages and states need to be cautious in what demands they place on the very employers who assist in "welfare to work" programs or who, subject to state regulations they find intolerable, self insure, and abandon the consumer protections of the fully insured marketplace.

A design feature of the original Dirigo Health Reform sought to pool all revenues to the Dirigo Health Agency(employer contributions, employee contributions and others), and use those pooled state resources to match Medicaid for eligible employees and their dependents. CMS has rejected our approach, which will soon be reviewed by the courts.

The states that followed us in this fourth wave of state health reform relied heavily on Medicaid, unlike Maine which coupled system savings with program financing. Vermont accepted federal flexibility in exchange for a block grant—like approach to Medicaid. Massachusetts built its program with $400M in Medicaid funds

that had been supporting their uncompensated care. We appreciate the strength of Vermont's initiative but find the block grant approach, which abandons a long established health care entitlement program, to be counter—intuitive to efforts to expand access and, like most states, we did not have access to the Medicaid funds now supporting Massachusetts' landmark reform.

Its time for a national policy to achieve affordable, quality health coverage for all.

States serving as laboratories of innovation have gained public attention and achieved much, filling a void in the absence of national reform. The laboratories of democracy were at work testing reforms reflected in later Congressional action. Many states had adopted insurance regulations before HIPAA was enacted; had well running children's health programs before SCHIP was born and developed Patients' Bills of Rights before Congress took them up.

The many and varied state experiments have been operational since at least the early 1970's. While states have done extraordinary work to lay the foundation for reform, each state is operating relatively independently based on very different health systems, coverage and costs and reflecting different state priorities. While experimentation has generated significant reforms, it has also created state—to-state variation that may also account for fragmentation and complexity across the country which drives costs. Over three decades of state health reform, and the reams of studies and evaluations analyzing them, suggest to me that it is time to get out of the laboratory and learn from decades of state experimentation. This is certainly not to say that there will not be a role for the states in any emerging national health reform but that a national solution-and national financing—is essential. We cannot reform our health system piecemeal or even by further state by state imitative. In the spirit of federalism, the national government must commit to a national policy that achieves affordable, quality health care for all of us.

We need a national policy that makes the roadmap clear that will achieve the reforms needed to address cost and quality and to cover all of so that the U.S. can take our place as health leaders—not as the country that spends twice as much, doesn't get any better health or quality and leaves 47 million without any coverage.

There are several obvious first steps that the Federal Government can take.

Complexity and redundancy are costs in the system. Streamlining and creating a single system—that does not necessarily require a single payer—would help. The Federal Government should examine its considerable purchasing power across Medicare, Medicaid, FEHBP, Champus and others toward standardizing reporting, payment policy, benefits, eligibility and quality metrics. If states are to play a role in health care reform, they need the capacity to work in a level playing field. ERISA prohibits much creative work and even the collection of key data from self insured businesses.

In the end, then, the ultimate question remains—who pays? For those of us who believe we are already paying more than we need to through cost shifting of the uninsured and the inefficiency in our health care system, cost containment needs to be a part of any reform. But ultimately, the nation's uninsured, a growing number of under-insured and all of us who have coverage now and fear for its future, need a reliable and sustainable source of financing to affordable, quality care-that does not sacrifice the access expansions in place now—that only a strong and consistent national policy can assure.

Chairman STARK. Mr. Haislmaier.

STATEMENT OF EDMUND F. HAISLMAIER, SENIOR RESEARCH FELLOW, THE HERITAGE FOUNDATION

Mr. HAISLMAIER. Thank you, Mr. Chairman, Ranking Member Camp, and Members of the Committee, for inviting me to testify today. My name is Edmund Haislmaier, I am a senior research fellow at the Center for Health Policy Studies at the Heritage Foundation, and I have to give you the caveat that my testimony is my own, and the Foundation does not take any institutional positions on these or other matters.

I come here, having spent the last 3 years—or more, actually—working with over 18 different states throughout the country, with

very diverse situations. And I would like to share in my 5 minutes some observations and conclusions that I have reached over the past 3 years. And I say, literally, diverse. I can recall a week last September when, on Monday, I was in Anchorage and the following Monday I was in Tallahassee.

First of all, to follow up on what some of the other panelists have said, I am impressed by the diversity of states. And that is in a number of areas: their demographics, their economies, and importantly, their health delivery systems. Because, remember health care delivery is always local. Also, in the financing arrangements, the way the insurance markets are regulated, and the way they design and operate their public programs.

Now, in looking at this from the federal and state perspectives, my key observation is that the Federal Government controls a significant portion of the financing of health care in this country. The tax treatment of health care is a key determinant of employer-provided health insurance—that is, the favorable tax treatment. Of course, the Federal Government sets the rules for Medicaid and SCHIP spending. And Medicare, while it is a Federal program, has a significant impact at the local level, because it is the disproportionate payer for hospital services.

So, that is what the Federal Government controls. The downside for the Federal Government control is they have virtually no regulation and no experience in the area of private insurance markets, nor do they directly regulate the providers: the doctors, the hospitals, et cetera. Thus, if you were to try to construct a national solution of some kind, you would inevitably have to tackle those issues.

Just think for a minute: What agency should be tasked with regulating health insurance? It is a very interesting question. We have never really come up with a satisfactory solution at the federal level.

Now, on the state side, the reverse is the case. They have to work within Federal constraints, particularly on the financing side of things. But they do have considerable powers to alter their private insurance markets, and to regulate providers.

So, I see, as the path forward, states working creatively—and I would emphasize creatively—within existing parameters of Federal law. And that is what I have been working with a number of states, as I said, on doing.

The more I do this, the more convinced I become that the path forward will be an evolutionary one, not a revolutionary one. I am convinced of that, because when I look at the politics and the interest groups, and the variables in the equation in any given state, they are enormous. And then I try to imagine multiplying that by 50, and coming up with a solution that is acceptable to everyone, and I have trouble seeing how we get there in one big bang.

What should the objective of health reform be? In my written testimony, I have gone on in some length on this. I believe the objective should be something that we very rarely hear talked about in health care. We hear talk about cost, access, occasionally quality, maybe even benefit. But the real missing word, in my view, is "value." Are we getting our money's worth?

I think that we can all agree that, both at an individual level and a societal level, we are either paying too much for what we're getting, or we're not getting what we should be for what we're paying. And that is both in terms of our personal interaction with the system, and also societal. In other words, we are spending all this money, yet we have these uninsured.

So, the question for me is how do we increase the value proposition in health care? How do we get more for less? How do we have health care work like other sectors of the economy, such as electronics, where next year's model has more features at the same price, or maybe even lower than last year's? That should be the objective.

Now, the mechanism, as I see it, that will get us there is to focus more on making the system and the actors in the system—the providers, the insurers, everybody else—respond to the needs and demands of patients and consumers. I use the term "consumer" to mean somebody who is buying insurance, but not at the moment seeking medical care.

What I think was significant about Massachusetts—and I wrote about this right after it was enacted—is that they essentially tackled two things simultaneously. And states that I have been working with are looking at doing one or the other, or both.

The first key element was insurance market reforms to create—and to work out the details of—exactly what Dr. Lewin pointed out, which is to work within the context of employer-provided insurance, but create a mechanism whereby the coverage was actually chosen by the individual, owned by the individual, and could be taken with them from job to job, but at the same time didn't lose any of the protections of Federal law, or any of the tax benefits, or the subsidies associated with that. That is the first piece.

The second piece—and, again, this is what Massachusetts embarked on, only in part, but other states are looking at going further—is to restructure the existing public spending, principally to shift from subsidizing providers for treating the uninsured, to using those dollars to buy the uninsured coverage. And I would submit, Mr. Chairman, that anybody who is interested in expanding coverage needs to look closely at that model. Because if you go about trying to expand coverage without making that financial shift, then you're, in effect, paying twice for the same thing, and you have got a tough road to hoe.

Anybody who is concerned about value, about quality, about competition, also needs to look at that, because if you perpetuate a system that subsidizes providers for their existence—particularly subsidizes certain providers, versus others—then you will never create the kind of competition where patients go and insurers steer people to the providers who offer the best results at the best price.

So, I think, from both the left and right, there is a lot to learn from that experiment.

Finally, let me conclude by saying that my bottom line in all of this is that we need to reform the incentives in the system, in terms of how private insurers operate, in terms of how the delivery system delivers care, to achieve better value, to create incentives where the winner is the one that figures out how to provide more people with better results, at a lower cost.

Once we do that, the task of making sure that everyone, without exception, is able to participate in the system, and that the disadvantaged are subsidized to buy into it, becomes, in my view, a much easier task, and is certainly doable.

Thank you very much. I will be happy to answer your questions.

[The prepared statement of Mr. Haislmaier follows:]

Statement of Edmund F. Haislmaier, Senior Research Fellow, The Heritage Foundation

Mr. Chairman and members of the committee, my name is Edmund F. Haislmaier. I am Senior Research Fellow in health policy at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Thank you for extending to me an invitation to testify before you today on state health reform initiatives. During the past three years I have had the opportunity to assist, in one way or another, health reform and coverage expansion efforts in about eighteen different states.

In the process I have been impressed by the interest of state lawmakers from both parties, and from widely differing states, in developing health reform solutions that are truly patient-focused and consumer-centered. I believe that putting patients and consumers first in health care is the key to creating a value-maximizing health system that includes all Americans.

Furthermore, my work with the various states has given me a greater appreciation for their diversity, including the diversity of their health care financing and delivery systems. I have come to believe that the most likely path to national health reform in the United States is through an evolutionary, not revolutionary, process resulting from a mix of state and federal initiatives.

With that perspective, I present in this written testimony what I view as the key principles for designing a health system that is truly patient and consumer-centered.

Key Principles

The fundamental objective of a patient-centered health care system is to maximize value for individuals and families so that they receive more benefit and better results for their health care dollars, both as patients and as consumers buying health insurance. Only when individuals choose and own their own health insurance will the other actors in the system—health plans and providers—have the right incentives to deliver better value in the form of improved results at lower prices.

If policymakers are serious about real patient-centered, consumer-driven health care reform, they should ensure that their legislative proposals embody six key principles:

- **Individuals are the key decision makers in the health care system.** This would be a major departure from conventional third-party payment arrangements that dominate today's health care financing in both the public and the private sectors. In a normal market based on personal choice and free-market competition, consumers drive the system.
- **Individuals buy and own their own health insurance coverage.** In a normal market, when individuals exchange money for a good or service, they acquire a property right in that good or service, but in today's system, individuals and families rarely have property rights in their health insurance coverage. The policy is owned and controlled by a third party, either their employers or government officials. In a reformed system, individuals would own their health insurance, just as they own virtually every other type of insurance in virtually every other sector of the economy.
- **Individuals choose their own health insurance coverage.** Individuals, not employers or government officials, would choose the health care coverage and level of coverage that they think best. In a normal market, the primacy of consumer choice is the rule, not the exception.
- **Individuals have a wide range of coverage choices.** Suppliers of medical goods and services, including health plans, could freely enter and exit the health care market.
- **Prices are transparent.** As in a normal market, individuals as consumers would actually know the prices of the health insurance plan or the medical goods and services that they are buying. This would help them to compare the value that they receive for their money.

- **Individuals have the periodic opportunity to change health coverage.** In a consumer-driven health insurance market, individuals would have the ability to pick a new health plan on predictable terms. They would not be locked into past decisions and deprived of the opportunity to make future choices.

The Key Tests of Reform

Not all health care reform legislation that is labeled consumer-oriented is equally effective or significant. The key test is whether or not it puts in place structural changes that maximize the ability of a large number of individuals to make basic choices about their own health insurance coverage and medical care.

Individuals are both consumers and patients. In a consumer-centered health system, individuals directly control the flow of dollars, buy and own their own health plans, pick the kinds of coverage that they want, and determine which plans offer them the best value.

In such a system, consumers expect transparent prices, and consumer choice stimulates competition among plans and providers to offer better value for money. That competition, in turn, drives innovation in both clinical practice and plan design. For individuals as patients and consumers, value for money is judged in terms of results: better medical outcomes, improvements in their health condition or status, cost-effective treatments, and health plans that save them money by helping them stay well and, when they do need care, by identifying the providers that offer the best results at the best price for their particular condition.

Thus, true consumer-centered health reform is system-focused reform, not product-focused reform. Its objective is to improve performance and results by changing the basic structure and incentives of health care markets so as to maximize value for money in health insurance and medical care. It is not simply an exercise in legislating new product designs or trying to plug gaps in coverage by crafting new programs for targeted subpopulations. Instead, true consumer-centered health reform focuses on making fundamental structural changes in the system, as opposed to merely expanding the existing system or micromanaging insurance plan designs or provider reimbursement methodologies.

Policymakers need to step out of the conventional mindset that accepts the basic structure of the present system as a given and attempts only to modify it around the edges. For example, legislative proposals to promote certain product types—e.g., health maintenance organizations (HMOs) and health savings accounts (HSAs)—may well have beneficial effects, but they do not fundamentally change how the system functions as long as someone else picks the health plan for the individual. Similarly, no amount of regulatory tinkering with provider reimbursement rates or payment methodologies can create more than marginal improvements in value as long as the system vests control over key decisions with employer and government "payers" who are not the ones receiving the medical care or using the health insurance policy.

Rather, consumer-centered health reform challenges policymakers to redesign the basic rules of the health care market to create new incentives for all of the actors in the system to put the interests of consumers and patients first.

Properly designed structural reforms will also produce a better framework and new incentives for addressing the current system's failings in cost, access, and quality more effectively. If responding to consumer needs and preferences is made the organizing principle of the system, then insurers and providers will have the right incentives to develop innovative ways to deliver better value to consumers and patients in the form of lower costs and improved outcomes.

In a reformed market, competition will produce new and better plan designs, clinical practices, and provider payment arrangements without lawmakers needing to micromanage the process. At the same time, it will generate new opportunities for lawmakers to focus public assistance more effectively to ensure that all Americans have access to the benefits of a system that offers better value.

The fundamental problem with the current system is that it encourages all participants (payers, insurers, providers, and patients) to engage in a giant game of cost-shifting, with each party trying to stick one or more of the others with a bigger share of the bill. Thus, while there may be plenty of competition in the present system, much of it is a zero-sum competition in which there is a loser for every winner. What America's health care system desperately needs are structural changes that create positive-sum competition in which all participants can "win" by working, often collaboratively, to improve the health care value proposition.[1]

[1] For a concise discussion of why structural change is needed and how to refocus competition on value maximization, see Michael E. Porter and Elizabeth Olmsted Teisberg, "Redefining Competition in Health Care," *Harvard Business Review*, June 2004. For a longer discussion, see

The Consumer As Key Decision Maker

The place to start examining any economic or social system is with its basic organizing principle, which is identified by asking "Who is the key decision maker in the system?" In any economic or social system, the key decision maker is the one who sets the parameters for the other participants in the system. The other participants must act in response to the needs or preferences of the key decision makers.

Political science clarifies this process. For example, in a democratic system of representative government, the organizing principle is popular sovereignty, identified by the fact that voters are the key decision makers. Other participants (e.g., office holders, public employees, lobbyists, and interest groups) operate within the framework of the preferences periodically expressed by voters in elections. To advance his or her interests successfully, another participant must ultimately persuade voters either that they already want what the participant is proposing or that they should want it.

This creates a cascading chain of incentives throughout the system. For example, the most successful way for a lobbyist to persuade a politician to vote for what the lobbyist wants is to show the politician how such a vote would be popular with voters.

Other political systems (e.g., monarchies, aristocracies, and dictatorships) have different organizing principles, each of which can be determined by identifying the key decision makers in these systems.

The same holds true in economics. Most market economic systems are "consumer-driven" because the individual customer is the key decision maker. The other participants (e.g., producers, shippers, wholesalers, and retailers) must operate within the framework of the consumers' preferences as expressed through their purchases. To advance their own interests successfully, the other players must find ways to persuade customers either that they are offering what the customers already want or that the customers should want what they are offering.

Again, the result is a cascading chain of incentives. Thus, the surest way for a shipper to get a producer's business is to demonstrate that it can deliver goods to retailers or consumers more quickly and at less cost.

As in politics, alternative economic system designs can be recognized by identifying the key decision makers and, thus, the systems' organizing principles.

For example, the organizing principle of a monopoly is that the economic sector is "producer-driven." A monopoly exists (whether by accident or by design) when only one producer provides a particular product, thus making that producer the key decision maker. With no alternative producers available, other participants in the sector (e.g., consumers and retailers) are constrained by what the sole producer decides to produce and its quantity, timing, and price.

Likewise, when suppliers collude, such as through a guild or cartel, the resulting market can be described as "supplier-driven," reflecting the fact that suppliers hold the key decision-making power in that particular sector.

The Health Care Sector Anomaly

In health care, on the supply side of the supply and demand equation are physicians, hospitals, and other health care professionals and institutions. Collectively, they are commonly referred to as health care providers. On the demand side are the patients who are seeking or receiving medical treatment. The broader term "consumer" encompasses not only patients, but also individuals who, while not actively seeking or receiving medical care, purchase related products and services, most notably health insurance.

In the U.S. and many other countries, health care differs from most other economic sectors because government policies have sponsored, promoted, and maintained an anomaly in the sector—an additional set of participants known as third-party payers. While individuals always ultimately pay the costs of any health system, governments have instituted policies that effectively divert a portion of their incomes into the hands of others (the payers), who then make the basic or key decisions on how to spend the money on behalf of patients.

The simplest variant of this arrangement is the single-payer system, in which the government taxes its citizens and then pays medical providers for treating them. The U.S. and some other countries have developed multipayer variants of the same basic model.

Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston, Mass.: Harvard Business School Press, 2006). See also Regina E. Herzlinger, *Who Killed Health Care? America's $2 Trillion Medical Problem—and the Consumer-Driven Cure* (New York, N.Y.: McGraw-Hill, 2007).

In multipayer health systems, the government is almost always one of the payers, but its role is more limited than in single-payer systems, typically operating tax-funded medical care payment programs only for certain subgroups of the population. For example, in the U.S., the Federal Government runs a tax-funded single-payer system for the elderly called Medicare, while the state governments run a similar system for the poor called Medicaid.

However, for the majority of individuals in countries operating multipayer health systems, the relevant third-party payers are private entities: most often their employers, although in some instances unions or associations. These private payers divert a portion of their workers' or members' income either to buy health insurance or to pay medical bills directly on behalf of their employees or members. These arrangements can be either mandatory, as in Germany, or voluntary, as in the U.S.[2]

Yet, in a voluntary third-party payment system, individuals are unlikely to hand over large chunks of their income and the authority to spend it without something that makes the arrangement significantly more advantageous to them than buying the services directly. That is particularly true for something as personal and important as health insurance and medical care.

In the U.S., these arrangements exist largely because employee compensation that is diverted through employers to buy the employees' health insurance is exempt from federal income and payroll taxes. In contrast, if workers wanted their employers to divert part of their compensation for other purposes—such as buying groceries, paying for their housing, or leasing cars for their personal use—they would find that tax law treats such arrangements as income and taxes the workers accordingly. While the law does not prevent employers and workers from entering into third-party payment arrangements for food, housing, transportation, or anything else, such arrangements are uncommon because they offer no clear advantage (tax or otherwise) to workers over receiving their compensation in cash and then paying directly for the goods or services of their choice.

The Evolution of the Health Care System

Current health care systems are a relatively recent phenomenon. They evolved in response to advances in biology, chemistry, and physics since the end of the 19th century that transformed medicine into a scientific discipline and an expanding economic sector. Even though the purpose of medicine is to better the lives and health of patients, the health care financing arrangements that evolved over the past century have never been truly consumer-centered.

Through at least the first half of the 20th century, health systems were essentially provider-centered. Patients were expected to defer to the judgment of medical professionals and to pay what was charged. It was considered highly unprofessional for physicians to engage in explicit price competition. Hospitals granted admitting privileges to physicians, and physicians referred patients to the hospitals where they had such privileges. Thus, a hospital's real customers were the doctors who controlled the flow of paying patients, not the patients themselves.

This basic structure persisted even as third-party payers, whether governments or employers, were introduced into the equation. Third-party payers were expected to pay the usual and customary charges billed by physicians and hospitals for their services, but not to question the benefits, quality, or value of these services. This provider-centered focus can be seen in early health insurance arrangements. For example, in the 1930s, hospitals organized Blue Cross and doctors organized Blue Shield to guarantee providers steady, predictable income streams by having patients—and later, their employers—effectively prepay for medical care on a subscription basis.

However, the resulting growth in the cost of medical care eventually spurred payers to start questioning the bills, beginning in the 1970s. At first, the focus was on the prices charged by providers. Payers, both government programs and private insurers working for the employers who were their customers, imposed payment limits on provider charges. Over time, those initial limits evolved into complex and comprehensive payer-imposed provider fee schedules.

However, as the payers soon discovered, prices constituted only half of the cost equation. Costs were still climbing thanks to steady increases in the volume and intensity of the medical care being provided. In recent decades, payers have tried to tackle this other half of the cost equation with a variety of restrictions on patient access to specific treatments or technologies.

---

[2] For a concise overview of the German health system, see David G. Green, Ben Irvine, and Ben Cackett, "Health Care in Germany," Civitas, 2005, at *www.civitas.org.uk/nhs/germany.php* (April 15, 2008).

The result is that today's health care financing systems, whether at home or abroad, are functionally payer-centered, with third-party payers having displaced providers as the key decision makers in the system.

In this specific sense, there is no qualitative difference between a single-payer system and a multipayer system. Both systems are payer-centered. Consequently, both systems generate the same incentives for other participants to respond to payers' demands and preferences rather than those of providers or patients. In a single-payer or a multipayer system, the payers decide whether or not to contract out to private insurers all or part of their role in managing the system, and they determine the terms and extent of such contracts. Private insurers therefore first serve the interests of the third-party payers who are their customers.

Thus, the relevant question is "For whom do the private insurers work?" not "Are private insurers part of the system?"

The Alternative: A Patient-Centered, Consumer-Based System

The obvious shortcoming of a provider-centered system is that it distorts the system in the direction of providing more, regardless of cost. The natural tendency of providers is to assume that increasing the volume and intensity of medical services will generate more benefit. Of course, this assumption is not consistently true. Depending on the circumstances, a particular test or therapy can be unnecessary or ineffective. Indeed, many medical interventions entail significant risks to the patient and can cause more harm than good. At other times, the modest benefits are not worth the costs.

In contrast, the shortcoming of a payer-centered system is that it distorts the system in the opposite direction by focusing on the cost side of the equation to the detriment of the benefit side. The most obvious, most effective, and simplest way to limit costs is by not spending money, but simply paying less or refusing to pay at all does not inherently produce more benefit or better value for the patient.

Furthermore, both a provider-centered system and a payer-centered system have an inherent bias to favor short-term considerations over long-term considerations. In a provider-centered system, the incentive is to do more now without adequately considering the possibility that such a course of action could produce a worse result later. In a payer-centered system, the incentive is to save money today without adequately considering the possibility that this could increase future costs.

Neither a provider-centered system nor a payer-centered system has the requisite incentives to maximize value systematically and consistently. Only consumers have a natural interest in a system that reduces costs while simultaneously improving results over the long term.

For any economic system to be value-maximizing, it must consistently and broadly reward consumers with lower cost and greater benefits if they seek the best value and must reward producers and suppliers with more business and higher incomes if they offer a better value than their competitors.

Thus, the foundational insight behind consumer-centered health care reform is that the only way to achieve better value in health care is to make the consumer the key decision maker in the system. Only when users and payers are the same will the incentives in the health care system properly align to seek and generate better value. Since third-party payers are never the users of the system—doctors and hospitals, not governments or companies, provide medical care to people—the only way to align the incentives to produce better value is to give those who use the system (patients and consumers) control over the funding and the associated spending decision. No other alternative arrangement can systematically and consistently produce more for less and secure value for the patient.

The Objectives of Patient-Centered, Consumer-Based Reform

The overarching objective of consumer-centered health care reform is to transform the health care market into one that maximizes value, meaning that the system's operational dynamic is competition among participants to produce better results at lower cost for patients and consumers. Once delivering better value to consumers becomes what enables other participants (e.g., doctors, hospitals, insurers, drug makers, and insurance agents) to "win" within the system, many of the current problems start to solve themselves. A consumer-centered system begins to control costs because it creates increased pressure to justify costs better in terms of demonstrated benefit. At the same time, a consumer-centered system generates pressure to improve results by demanding data showing that anticipated benefits are commensurate with expected costs.

Consumer choice also creates stronger incentives for measuring and reporting quality and performance because consumers need that information to make better decisions, thus producing improvements in those areas as well. Even a portion of

the access problem begins to solve itself. When health insurance attaches to the person instead of to the job, fewer people encounter circumstances in which they lose their health insurance coverage, and the size of the uninsured population is commensurately reduced.

A secondary objective is to provide lawmakers with a better foundation on which to build complementary public policies that more effectively address those access issues that competitive markets alone cannot solve. For example, the existence of a consumer-centered market for food makes it easier for policymakers to assist those who need help beyond what the market can provide through such means as subsidies in the form of food stamps or targeted incentives for grocery stores to operate in economically or geographically marginal, underserved areas. In a similar fashion, the presence of a consumer-centered, value-maximizing health system would allow lawmakers to focus tax dollars on helping those individuals who are financially or geographically disadvantaged to "buy into" a well-functioning system.

Another secondary objective is to encourage greater innovation. In this regard, health system innovation encompasses not only medical innovation to produce new and better treatments and therapies, but also innovation in organization and financing such as developing better clinical practices for treating patients, better provider payment arrangements, and better insurance plan designs.

This last point is particularly important. By putting the interests of patients and consumers first, a consumer-centered system forces other participants, particularly insurers and providers, to rethink their relationships and interactions. The current confrontational dynamic, in which providers try to force payers to spend more and payers try to force providers to charge less and do less, becomes an unproductive strategy for both sides because it does not produce the better value that consumers want. Instead, in a consumer-centered market, providers and insurers would find that they can both win (gain market share and increase income) if they collaborate to deliver better value (more benefits for less costs) to patients and consumers. This forces them to think more creatively and urgently about how providers can improve their quality, results, and efficiency and how insurers can restructure provider payment and contracting arrangements to capture newly created value and pass the savings and benefits on to their customers.[3]

The Key Principles of Real Reform

Lawmakers looking to design the right policy framework for enabling a consumer-centered, value-maximizing health system need to start with six key principles.

Principle #1: Individual consumers are the key decision makers in the system.

In a consumer-centered health care system, individuals are the key decision makers with respect to medical treatments and health insurance. The current payers in the system (governments and employers) will still play an important role, but in a different fashion. They will no longer manage the details of the system, but will instead play supporting roles in assisting consumers, who become the system's primary decision makers. The role of employer will center on providing their employees as consumers with financial engineering and decision-support services.

The financial engineering aspect encompasses various employer strategies to help workers participate in the system more efficiently. For example, the workplace is a convenient location for distributing information and handling administrative tasks, such as workers choosing coverage from a menu of options during an annual open season. Similarly, employer participation in an automatic payroll deduction system for insurance premiums is an administrative efficiency that benefits workers at very little cost to employers.

Most important, as long as federal tax policy treats worker compensation for health care as tax-free to the worker if it is passed through the employer's hands, employers can leverage the tax code to ensure that their employees' spending on health insurance and medical care takes advantage of that favorable tax treatment. Doing so effectively lowers the cost of health insurance and medical care to workers by 15 percent to 50 percent because workers do not pay taxes on this compensation.[4]

---

[3] See Porter and Teisberg, "Redefining Competition in Health Care" and *Redefining Health Care: Creating Value-Based Competition on Results*.

[4] The value to a worker of the tax exclusion for employer-sponsored health insurance is equal to the combined marginal income and payroll tax rates that would be imposed if the compensation were instead paid to the worker as taxable cash income. For a low-wage worker with no federal income tax liability, the tax exclusion is worth 15.3 cents per dollar of health benefits, reflecting the combined employee and employer payroll (FICA) tax rate. Thus, the value of the tax exclusion for that worker is effectively a 15 percent discount on the cost of buying health insurance. For a worker in the 28 percent income tax bracket, the value of the tax exclusion

Employers can also play a decision-support role by assisting their employees with information and guidance in making health care choices. Most often, this will take the form of the employer or an insurance broker under contract with the employer helping individual workers pick the insurance plans that best suit their personal circumstances and preferences. Employers can also offer their employees a range of related services, such as workplace clinics; health promotion programs; information on the costs, risks, and benefits of common treatments; and comparative data on the quality and results of health care providers. Employers inclined in this direction will find that numerous vendors already exist who are willing and able to bring these and similar programs into the workplace.

For governments, their role in a consumer-centered system shifts to financial assistance. Ultimately, the goal should be for the government to stop trying to design and operate public health insurance plans and instead focus on providing disadvantaged individuals with the necessary funds to buy into the same consumer-centered system that everyone else uses.

This will primarily take the form of steps to shift public assistance from a defined-benefit model to a premium-support model. In the current defined-benefit model, the government operates separate public health insurance plans for specified subsets of the population—something that government is poorly equipped to do competently. In a premium-support model, the government would operate programs to supplement the incomes of those who do not have sufficient funds to buy adequate health insurance and medical care in the market, just as the government now does with food stamps to help the poor buy groceries.

In some places, such as rural areas or economically distressed locations, governments might also provide assistance in the form of targeted subsidies or incentives to ensure that essential health services are available—for example, by funding clinics or offering inducements to health professionals to practice in those areas.

Principle #2: Individuals buy and own their own health insurance coverage.

For a health system to be consumer-driven, health insurance coverage must be purchased and owned by individual consumers. In other words, the coverage contract must be an agreement between the insurer and the individual consumer. If the contract is between the insurer and some other party, such as an employer or a government, then the other party, not the individual consumer, is the insurer's real customer.

While at one level a coverage contract is a legal arrangement, it is primarily an economic arrangement. The legal aspects of the contract simply define the specifics of the underlying economic arrangement between the insurer as the supplier and the counterparty as the customer. As a supplier, the insurer is legally obligated and economically motivated to work in the interest of its customers. However, when the counterparty is an employer or government, that entity becomes the insurer's customer, and the counterparty's interests may differ from or be contrary to the individual's interests, even if the coverage is ostensibly purchased for the individual.

A simple analogy illustrates this key point. When a parent purchases breakfast cereal for a child, the customer is the parent, not the child. The parent and the child may have different opinions as to the best cereal to purchase. Indeed, these different opinions likely result from differences between the interests and preferences of the parent and the child. For example, the child likely prefers flavor over nutrition, while the parent will likely view nutrition as more important than flavor. Of course, the child's preferences likely influence, at least partially, the parent's decision, and cereal makers may even try to exploit this by pitching advertising to the child in the hope that he will influence his parents.

Ultimately, the buying decision rests with the parent, who is therefore the cereal maker's true customer. For the child to be the customer, the child must make the purchasing decision, using either his own money or money given him by a parent. Absent such a shift in decision-making authority, to sell more cereal, the cereal maker must first make its products attractive to the parents who will buy them, regardless of how attractive it makes the cereals to the children who will eat them. This means that the cereal maker must focus on the aspects that matter most to parents, such as nutritional content or pricing that gives them good value for their money.

---

is 43 percent (15 percent payroll tax plus 28 percent federal income tax) and, depending on the applicable state income tax rate, can approach 50 percent when avoidance of state taxes is included.

While parents letting their children choose which breakfast cereal to buy is probably not a good idea, having individual consumers—not their employers or the government—choose their own health insurance plans is a good idea.

Principle #3. Individual consumers choose their own health insurance coverage.

Individual ownership of coverage is an essential criterion for a consumer-driven market, but it is not the only criterion. A market characterized by individuals purchasing the product is still not a consumer-driven market if only one product is available, if there is only one supplier, or if the suppliers are organized in a cartel.

In such monopolistic circumstances, the lack of meaningful choice for consumers means that the key decision-making power still resides on the supply side of the economic equation. For the market-shaping power of the key decision maker to shift from the supply side to the demand side, consumers must have a choice of competing products and suppliers. Only then must suppliers respond to consumers instead of the other way around.

The linchpin of a consumer-centered health care market is the opportunity for individuals to choose the health insurance coverage that best suits their own preferences. While choice of health care providers is certainly essential to a well-functioning, consumer-centered market, the ability to choose among a diverse array of competing health insurance plans is the most important feature. This is true for two reasons.

First, health insurance is the principal mechanism for financing medical care. Indeed, this is true even when consumers opt for high-deductible plans and purchase much of their routine medical care directly from providers. For a health system to be truly consumer-centered, individual consumers must ultimately decide how the money in the system is spent. Thus, the first and most basic decision that consumers must be allowed to make is which health insurance plan to purchase.

Second, the choice of a health insurance plan of necessity incorporates a whole set of other implicit choices, such as what the plan will pay for versus what the consumer will purchase directly from providers, how and from whom the consumer will receive care, and how the plan will assist consumers in deciding among competing providers and treatment options. This last consideration is particularly important. Even the most sophisticated consumer may not have all of the relevant information available or have sufficient time to gather and analyze it when deciding among providers and treatments. However, health plans have—or should have—the information and expertise to assist consumers in making these decisions.

What consumers want is good value—meaning the best medical care at the best price. In a competitive market in which consumers choose their own health insurance, insurers succeed and prosper by offering consumers a better value proposition than their competitors offer. In other words, they apply their data and expertise to finding their customers the best medical care at the best price or, better yet, to finding ways to help their customers minimize their medical spending by staying or becoming healthy.

Thus, when individual consumers decide which insurance plan to purchase, insurers become the consumers' expert agents, helping them to navigate the health care system and obtain the best results at the lowest cost.

Principle #4: Individuals have a wide range of coverage choices.

In any truly consumer-centered market, multiple suppliers compete to offer consumers better products at better prices. Yet for market competition to produce better value consistently—that is, by simultaneously increasing benefits while decreasing costs—consumers must be free to choose from a range of different options, and suppliers must have wide latitude to innovate in meeting consumer demands and preferences with new and better products. Thus, a precondition to any well-functioning, consumer-centered market is that lawmakers avoid unduly restricting either the options available to consumers or the scope for supplier innovation.

Government does need to set some basic rules for any well-functioning market. Much like establishing product safety standards or a uniform system of weights and measures, government can establish rules that facilitate well-functioning markets without unduly restricting supplier innovation or consumer choice. However, for a competitive market to function optimally, the basic rules need to permit wide scope for suppliers to innovate in developing new and better products and features to meet consumer needs and preferences.

Furthermore, lawmakers need to recognize that not all consumers have the same needs, preferences, or priorities. Suppliers must be free to innovate in offering different products to different subsets of consumers, targeting their different needs and preferences. This is particularly important in the health care sector where con-

stantly expanding scientific knowledge and the resulting innovations in medical treatment force continual reassessment of what is "best" for individual patients and specific medical conditions.

For example, in health care, it is appropriate for government to limit the practice of medicine to those who demonstrate adequate knowledge and skill, but lawmakers should avoid inappropriately restricting provider competition with rules beyond those necessary to ensure basic provider competence and patient safety. Likewise, lawmakers should also take care to avoid imposing regulations that needlessly micromanage providers, stifle innovation in clinical practices, or favor one set of providers over another.[5]

In the same fashion, lawmakers need to set basic standards and rules for health insurance products and the companies that offer them. Yet they need to resist the temptation to substitute their judgment for the consumers' judgment.

In setting health insurance market rules, lawmakers should focus on establishing the broad market parameters and allow market competition to work out the details. For example, in setting coverage standards, lawmakers should limit themselves to specifying basic coverage categories, such as physician services, hospital services, and prescription drugs. They should avoid micromanaging the market by, among other things, imposing coverage mandates for specific conditions or treatments or by stipulating how plans must contract with providers.

Similarly, lawmakers should not enact measures that favor one particular plan design over others. Government policy should treat all plan designs (e.g., HMO, preferred provider organization (PPO), indemnity insurance, and HSA with high-deductible insurance) equally. Such an approach not only permits beneficial competition and innovation, but just as importantly respects and accommodates differing personal preferences among consumers.

Principle #5: Prices are transparent to consumers.

The same holds true in establishing rules for the price side of the price/benefit equation. In all cases, lawmakers should avoid direct "price setting" because such interventions inevitably distort the market in ways that end up harming both suppliers and consumers.

Yet government does play a legitimate role in ensuring that a market functions fairly and smoothly by establishing basic pricing rules, which enable consumers to comparison shop effectively by clearly informing them up front about the price of each option. For example, government requires grocers to include the unit price on the label of products sold by weight or volume and requires lenders to disclose the effective annual percentage rate (APR) of a loan when offering financing to prospective borrowers.

In a similar fashion, lawmakers will need to reach agreement with stakeholders on the appropriate standards for calculating and communicating prices to consumers in the health system. While enhanced price transparency at the provider level will certainly improve the functioning of the health system, the bigger issue will be the rules for how insurers price their health plan offerings.

Because insurance premiums can be calculated in a number of different ways, lawmakers need to establish rules for reporting those prices so that consumers can comparison shop among the different offerings. In other words, which factors and parameters will be used in reporting prices? Will prices (premiums) be reported on an age-adjusted basis? If so, will the competing plans produce rate tables priced in one-year age increments, or will five-year age increments be sufficient for insurers and simpler for consumers? Lawmakers will need to address similar questions about other possible rating factors, such as geography and family status.

Regardless of the specifics, lawmakers need to establish some set of basic rules on reporting premiums. Otherwise, if competing insurers priced their plans in dif-

---

[5] Examples of such counterproductive regulations include certificate-of-need laws that restrict the availability of medical facilities, technologies, or services; insurance benefit laws that dictate how plans are to pay certain favored health care providers; and laws that unreasonably restrict competition among providers, such as ones that bar the creation of specialty hospitals. For further discussions of these various regulations, see Michael J. New, "The Effect of State Regulations on Health Insurance Premiums: A Revised Analysis," Heritage Foundation *Center for Data Analysis Report* No. CDA06—04, July 25, 2006, at *www.heritage.org/Research/HealthCare/cda06–04.cfm*; Ashok Roy, "How Congress Is Killing Competition: The Future of Specialty Hospitals," Heritage Foundation *WebMemo* No. 1740, December 13, 2007, at *www.heritage.org/Research/HealthCare/wm1740.cfm*; U.S. Federal Trade Commission and U.S. Department of Justice, *Improving Health Care: A Dose of Competition*, July 2004, at *www.justice.gov/atr/public/health_*care/*204694.htm* (April 15, 2008); and Patrick A. Rivers, Myron D. Fottler, and Mustafa Zeedan Younis, "Does Certificate of Need Really Contain Hospital Costs in the United States?" *Health Education Journal*, Vol. 66, No. 3 (September 2007), pp. 229—244.

ferent ways, or if insurers customized the premium charged to each individual customer, it would be difficult or even impossible for consumers to comparison shop among plans. Without some agreed convention on reporting prices, the balance of power in the market shifts back to the supplier because the answer to the consumer's question "What is the price?" becomes "It depends." This makes it difficult for consumers to weigh the relative costs and benefits of competing options accurately and makes the market supplier-driven instead of consumer-driven.

The specifics of the pricing convention are less important than making certain that some standard pricing convention is used. For example, for many years the standard convention on the New York Stock Exchange was to price stocks in eighths of a U.S. dollar, while the London Stock Exchange used hundredths of a British pound. Although they used different pricing conventions, both markets worked equally smoothly. Indeed, when U.S. stock markets switched to using hundredths of a U.S. dollar, some market participants fared marginally better or worse than they had fared under the previous convention, but the markets continued to function smoothly. In contrast, a stock market would become less transparent and less efficient if each company was listed using its own choice of currency and fractional system.

In setting these and other market parameters, lawmakers should focus on ensuring that the resulting rules are transparent and equitable to consumers and that they provide insurers with a level playing field while accommodating their legitimate business concerns.

Principle #6: Consumers have regular opportunities to make coverage choices on predictable terms.

For a market to be truly consumer-centered, individuals must be able, at least periodically, to reconsider past purchasing decisions and make different ones. A market that restricts consumer choice by unreasonably locking consumers into past decisions also has the effect of shifting the balance of power in the market back to suppliers.

For example, if a market rule locked consumers into buying new cars only from the manufacturers of their first cars, this would clearly shift market power from consumers back to suppliers and reduce producer competition and its resulting benefits. With much of its customer base locked into its product line, each producer would have significantly less incentive to respond to consumer demands for better products, more innovative features, and lower prices.

For the health insurance market to be truly consumer-driven, a clear set of rules must establish when and under what terms consumers can choose among competing options. Otherwise, adverse selection or constant churning could undermine the stability and viability of these markets. Nonetheless, these rules need to ensure that the market puts the interests of consumers firmly ahead of the interests of suppliers (the insurers) while still accommodating the legitimate business concerns of the suppliers.

This feature of consumer-centered health reform will likely be the most unsettling to many insurers because it will require them to adjust their business practices to accommodate a new market dynamic in which the customer picks the supplier. In the current dynamic, the supplier picks its customers through various strategies that focus on selling to some potential customers but not to others.

In setting this portion of the market rules for a consumer-centered system, lawmakers need to start from a clear understanding of both the product in question and the needs and behavior of consumers.

A significant portion of any health insurance plan is not insurance in the classic sense of financial protection against unpredictable risks or costs. All health insurance plans still retain some element of this protection, but it is no longer their primary feature. Rather, a large share of health insurance today consists of prepayment for medical care of varying cost and predictability. While the concept of using health insurance to pay for a full range of possible medical care was originally developed decades ago to serve the providers' interest in having more predictable income, that concept has since superseded its original intent.

Today, health insurance plans are a way for consumers to manage their need to finance medical care of varying predictability. In recent decades, advances in medical science have steadily made more medical services more predictable for more patients. Furthermore, the current trends in scientific discoveries and their practical applications in the clinical setting will make even more medical care more predictable for more patients in the future. This is an irreversible dynamic that is driven by steadily expanding knowledge in the basic sciences of biology, chemistry, and physics, closely followed by constant practical innovation in applying that knowledge to the development of new tests and therapies.

This ongoing scientific evolution has several practical implications for health insurance and health insurance markets. *First,* it is no longer practical or desirable for policymakers to attempt to fight the rising tide of scientific knowledge by trying to restrict health insurance plans to paying only for the limited and ever-shrinking share of medical care that is genuinely unpredictable. Even the more consumer-directed plan designs that limit coverage by requiring subscribers to pay directly for more of their routine care will need to evolve to accommodate this new reality—for example, through mechanisms to ensure that incentives are properly aligned between the care that subscribers purchase directly and the care paid for by the plan—so that the totality of treatment is integrated and produces optimal results. While such plans will continue to attract a share of consumers, they will need to demonstrate in a competitive market that the total proposition offered—the combination of services paid directly by the consumer and services reimbursed by the plan—is a good value compared to other plan designs and produces a combined outcome for the consumer that is as good as or better than that offered by alternative, competing arrangements. *Second,* plans will need to become more of the consumer's "expert agent" who works to identify for customers the best providers and treatment options available at the best prices. Some current business practices, such as negotiating provider contracts based mainly on price and then steering patients to those providers, will not compete adequately in a value-maximizing market.[6] Instead, plans will need to develop new strategies. For example, they might cover all providers in a given market but vary patient co-pays according to an analysis, which the plan makes available to its subscribers, of which providers offer the best results at the best prices. Pharmacy benefit managers have already pioneered such a business strategy in the form of tiered co-pays for different competing drugs. *Third,* a consumer-centered system will need to curtail some current insurer underwriting practices that exclude, limit, or charge above-standard rates for coverage for certain individuals or certain medical conditions. While these traditional practices will need to be retained in a limited form as penalties against those who wait until they are sick to buy coverage, they cannot be applied when individuals with coverage choose a different plan if the new market is truly consumer-centered. One of the important incentives for purchasing health insurance when an individual is healthy must be the assurance that future changes in health status will not disadvantage the individual when retaining existing coverage or choosing new coverage.[7] *Fourth,* as science increasingly makes more medical care more predictable, health plans must recognize that they are increasingly less in the business of cross-subsidizing unpredictable risks and more in the business of cross-subsidizing health status. In this regard, cross-subsidizing health status is not only a horizontal exercise—commonly understood as the healthy paying for the sick—but also a longitudinal one in which a healthy person today will probably be in poorer health at some point in the future or even vice versa.A competitive, consumer-centered system will force insurers to rethink some of their business practices in this area as well. For example, insurers might experiment with offering features such as multi-year contracting, premium discounts for participation in wellness or disease management programs, or cash rebates to subscribers who successfully meet agreed-upon health improvement goals. These and other novel plan designs can create powerful new incentives for consumers, providers, and insurers to work together to achieve better value by keeping or making consumers healthier at a lower cost. *Fifth,* lawmakers must ensure that the market rules in this regard are fair to consumers, while also accommodating the legitimate business concerns of insurers. For example, if consumers are to be able to choose coverage at standard rates regardless of health status, it will be necessary to limit when consumers can make these choices to avoid confusion in the market. For instance, consumers could be limited to choosing or changing coverage only during an annual open season, or for some other fixed period of time, with exceptions for special circumstances such as loss of employment or loss of coverage under a

[6] See Porter and Teisberg, "Redefining Competition in Health Care" and *Redefining Health Care: Creating Value-Based Competition on Results*.

[7] As a practical matter, in the employer group market, federal law already provides for limited guaranteed issue of coverage and prohibits individual medical underwriting. Consequently, consumer-centered insurance market reform within the existing framework of employer-sponsored coverage will focus primarily on expanding the coverage options available to workers and shifting ownership of the policy from the employer to the individual. That way, coverage becomes truly portable and the interests of insurers are aligned with those of consumers who are seeking better results for their health care dollars. Such changes in the employer context are analogous to the changes introduced by 401(k) plans, which created the option of individual choice, ownership, portability, and control within the framework of tax-favored employer-sponsored retirement savings. The more contentious aspect will be expanding those same rules to include the non-group market as well.

spouse's plan.Similarly, lawmakers will need to work closely and cooperatively with insurers to devise risk-adjustment mechanisms to give insurers incentives not to avoid subscribers with health problems, but rather to help them get better outcomes at better prices or even to specialize in identifying and organizing cost-effective treatments for patients with specific conditions, such as diabetes, cancer, and heart disease. The market will need risk-adjustment mechanisms that allow each insurer to accept all customers regardless of their individual health status and that permit all insurers to aggregate a portion of their large claims and equitably redistribute these costs across all consumers in the market.[8]

Conclusion

The current debate over health care reform is usually framed in terms of addressing cost and access problems, accompanied by occasional discussions about the need to improve quality and outcomes in the system. Yet those issues are all manifestations of a more fundamental dissatisfaction with the status quo. Implicitly, both policymakers and the public are motivated by a sense that health care today is not living up to their expectations for value at either the individual level or the societal level.

While America's current health system has clear strengths, it also has significant weaknesses. For all the benefits that it provides in helping people to live longer and healthier lives, America's health care system seems too costly, confusing, inefficient, and uneven in its results, and it leaves too many people without adequate access to its benefits. Fundamentally, Americans as individuals and as a society intuitively recognize that the present health system could do a much better job of delivering value.

Put simply, Americans rightly sense that either they are paying too much for their present health system or the system should be delivering better results given what they are already paying.

The solution and the challenge for policymakers is to undertake the reforms needed to transform the present system into one that does a much better job of rewarding the seeking and creation of better value. As the experience of other economic sectors shows, health care need not be a zero-sum game in which costs can be controlled only by limiting benefits and benefits can be expanded only by increasing costs. Rather, a value-maximizing system will simultaneously demand and reward continuous improvements in benefits while continuously reducing costs.

Such a value-maximizing result can be achieved in health care only if the system is restructured to make the consumer the key decision maker. When individual consumers decide how the money is spent, either directly for medical care or indirectly through their health insurance choices, the incentives will be aligned throughout the system to generate better value—in other words, to produce more for less.

All Americans should be able to agree with the goal of creating a value-maximizing health care system. Consumer-centered health care market reforms are the only effective means for achieving that goal.

This concludes my prepared remarks. Thank you Mr. Chairman and members of the committee for the opportunity to testify today. I will be glad to answer any questions you may have.

The Heritage Foundation is a public policy, research, and educational organization operating under Section 501(C)(3). It is privately supported, and receives no funds from any government at any level, nor does it perform any government or other contract work.

The Heritage Foundation is the most broadly supported think tank in the United States. During 2006, it had more than 283,000 individual, foundation, and corporate supporters representing every state in the U.S. Its 2006 income came from the following sources:

Individuals 64%
Foundations 19%
Corporations 3%
Investment Income 14%
Publication Sales and Other 0%

The top five corporate givers provided The Heritage Foundation with 1.3% of its 2006 income. The Heritage Foundation's books are audited annually by the national accounting firm of Deloitte & Touche. A list of major donors is available from The Heritage Foundation upon request.

---

[8] For a further discussion of risk-adjustment mechanisms, see Edmund F. Haislmaier, "State Health Care Reform: The Benefits and Limits of "Reinsurance," Heritage Foundation *WebMemo* No. 1568, July 26, 2007, at *www.heritage.org/Research/HealthCare/wm1568.cfm*.

Members of The Heritage Foundation staff testify as individuals discussing their own independent research. The views expressed are their own, and do not reflect an institutional position for The Heritage Foundation or its board of trustees.

Chairman STARK. Well, thank you all. I—it is an amazing and complex problem.

Let me just try a couple of issues that I have been concerned about, and maybe we can—there is this—if there are no children in the audience—a horrid word—a few back there? Oh, I am sorry. But in mixed company, and in polite society, this word "mandate" has caused great concern among parents. They rush to their children, put wax in their ears, and get them out of the room.

But last time I looked, the former Governor of Massachusetts who I don't recall ever being accused of being a flaming liberal. And I don't recall Governor Schwarzenegger being accused of being a Socialist, save perhaps in Germany or Austria. But both were able, one way or another, to use that word "mandate." And I suspect we have it in auto insurance and driver's licenses and income—we have a lot of mandates in our lives.

Is there—are there any of you who feel that we can achieve, over a period of time, universal coverage and a reasonable quality of care for all of our residents, without using mandates, whether it is requiring certain groups—businesses to pay, for example, or all people to have a policy, or have a provider, if they can afford it? Is there a major objection to a mandate? Jack?

Dr. LEWIN. Well, I think that—you know, we don't have anything to point to in this country, Chairman, that would indicate universal voluntary anything. We really don't have any universal voluntary programs out there.

So, I think if we want everybody to be covered, and we want everyone to pay their fair share, including the immortal and young, who think that they can avoid coverage, but also those who really need the coverage and can't afford it, I think we need to make a policy that is either a mandate, or an incentive so strong that they're the equivalent of a mandate.

Chairman STARK. Anybody else? Ms. Bigby.

Dr. BIGBY. I think that the individual mandate is a key part of reform in Massachusetts, and we have a recent survey that demonstrates that the majority of people in Massachusetts actually support the mandate, and do not think that it should be repealed. I think the key is the mandate is for people who have access to affordable insurance. And defining affordability and a mechanism for ascertaining affordability and having alternatives, I think, is key to implementing a mandate.

Chairman STARK. Mr. Haislmaier, given a plan that would meet your other requirements of people being able to select on the basis of quality and price, can you—could you live with, say, for these plans to work, everybody has to be in them, and some groups have to pay——

Mr. HAISLMAIER. The answer, Mr. Chairman, is yes to maximize coverage to everyone; and, for the system to work with maximum efficiency, everyone has to be in that.

However—and this is important—there are different mechanisms for getting to that point. There is no one single mechanism. And one can disagree as to how it is done.

I would simply make an observation, if I could, about what happened in Massachusetts. Governor Romney did not initially propose an insurance mandate. What he said is that, under the plan that he submitted to the legislature, insurance would be made more affordable. It would create a mechanism where it would be easier for employers to at least offer the coverage, since they wouldn't have to, you know, run their own plan, they could simply bring people to the Connector and let them choose. So, there was no reason to not offer the coverage. And finally, the insurance would be subsidized for those below 300 percent of poverty.

And the position that he took in his initial proposal was, "Okay, folks, you've kind of run out of excuses, if we do all these things, for not having insurance. So I am not going to make you buy it, but I am going to say that you have to live with the consequences if you don't. Because if you don't buy it, and then you go and get treated, and then you don't pay your bill, well, it's not the fault of the hospital, it's your fault."

Now, the legislature, in its wisdom, turned that into a "buy insurance or we will fine you" mandate. Okay, one could——

Chairman STARK. No death penalty?

Mr. HAISLMAIER. Pardon?

Chairman STARK. Just a fine? No death penalty?

Mr. HAISLMAIER. No death penalty, no, it was a fine. And one can disagree, as to the approach. But I think, philosophically, they are the same thing.

The point I would make is that what happened in Massachusetts is that they tried to design their reforms so that everyone participating—individuals, the providers, the employers—would see it as a good thing, and want to participate. And it was only at the end of that process did they then say, "Well, now, do we need to make people buy it?"

And the concern that I have is that, if you start by saying, "Well, we are going to make everybody buy it," then you skip the necessary hard thinking about, "Well, what do we have to do to make people want this without requiring them to buy it," because that is going to make a difference, as to how effective it is. If people just want it, regardless of you requiring them, then any requirement is really to clean up the last two or 3 percent.

Chairman STARK. That is fine. Thank you. Mr. Weil, I think you suggested that we need Federal action. Can you give me—I would think of issues like setting some kind of minimum benefit standards, the issue of how we deal with Medicaid, as opposed—if we set a national standard, Medicaid, Medicare, how do we get those—you know, can you give me a couple or three areas in which you think Federal action would be the most important?

Mr. WEIL. Mr. Chairman, first and foremost, there needs to be a national commitment to universal coverage. Without that, the ability of states to feel confident in the resources and in their ability to move forward, I think everything else will suffer without that.

And, of course, once you talk about universality, you do have to answer some important questions: What does that mean; What are the standards to give people confidence that they will have coverage?

We already have a lot of leadership from the Federal Government around quality improvement. But we could use more. The field—I think the discussion about value is actually very much on the table now, and the ability of the Federal Government to lead and work as the dominant purchaser with states as major purchasers in their domain, it provides tremendous opportunity for forward progress.

And issues of cost. We simply can't—everyone says the incentives are wrong, and then they go off and do their own thing to fix the incentives, and the incentives continue to be fragmented, and they continue to be wrong. And if we are going to actually reach any agreement to try to align those incentives to improve the value in the system, the different purchasers have to work together, and within any given state, the Federal Government and the state are right up there at the top.

I think there is potentially a very long list of areas for cooperation between the Federal Government and the states. But, as I say, really what the country needs, first and foremost, is a commitment to universal coverage. And then states within that framework, I think, could go a long way.

Chairman STARK. Jack, could you just expand a little bit on the issue—it's one with which I agree—but beyond the idea that we have got, what, 160 million people who now get insurance through their place of employment, and the idea that we would suddenly say to those 160 million people, "Well, wipe it clean, and we're going to give you a nice plan that Dave Camp and Pete Stark write," you would scare the begeezus out of 160 million people, or at least 159 million of them, right away.

And so, I have felt that there is a political issue of just saying we are going to disband the coverage that this many people have. Are there other reasons that you think we have to—we should keep that part of any plan?

Dr. LEWIN. Yes, I do. Thank you, Mr. Chairman. You know, I think that we—first of all, the employer-based system works fairly well for most parties. What we don't have there is portability, we don't have—we need some insurance reforms, and as we mentioned before, there is the issue of choice of coverage that we need to expand.

So, if we could add those features to employer coverage, we would strengthen that. And I would fear that were we to even send the message that we are moving away from employer coverage—and we have seen erosion of employer coverage in many places: California, in particular. What happens there is we're more likely to shift people to the public sector in a way that we couldn't accommodate the absorption of the cost and really handling of that.

So, if, over time, our long-term policy was individual coverage, and we had a long ramp-up period to it, I would imagine we could find a way to get there, and it could work. But I think it would be precipitous and dangerous to send that message now, with the vast majority of people covered there.

Some employers are beginning now to take some actions, as well, to strengthen the health of their workers, and recognizing that they have got another role, in addition to being the administrators and the accountants, if you will. And I think there is some hope out there that employers could be encouraged to do some more activities.

You see what Safeway is doing, for example, for its employees, and other large corporations that are deciding to take some matters into their own hands, and through voluntary approaches, incentivizing healthy behaviors and rewarding those behaviors, without penalizing people who have, for genetic reasons or other reasons, a health problem that they can't—that needs attention.

So, I think there is a lot going in the employer side right now that we should retain. If we want to focus on those sectors that don't provide employer-based coverage—retail, agriculture, food services, small businesses—that is maybe where we could make the gains with individual coverage, to start the process there, and maybe that is a way to avoid a fight, if you will, with some entrenched sectors that would make it hard for us to make some progress.

So, there is a reason, I think, to approach those sectors with individual coverage. But I think, for the rest of the marketplace, we ought to try to protect employer coverage, and improve it.

Chairman STARK. Let me ask, if I may, Dr. Bigby, and go on. But we have heard the issue of quality mentioned time and time again. My concern is that we really don't now have the ability or the data to determine quality in any kind of an empirical manner. And unless and until we get outcomes research—which would probably take us 5 or 10 years of accumulating data—that the idea of, you know, what one internist is—are they worth $70 for a 15-minute consultation, or is another one worth $100?

I don't know that there is any way on God's green Earth that one can determine that without this database. That is—don't we have to do a lot of work to build the data information before we can start to say we're going to pay for quality?

Dr. BIGBY. I think that that is absolutely right. One of the features of Massachusetts's health care reform was the creation of the Health Care Quality and Cost Council, and a requirement that that council post cost and quality data for providers in Massachusetts. We are working very hard to get those data up on a consumer-friendly website.

But the things that we are struggling with is that we have very few measures of quality. Those individual measures of quality don't give us an overall measure of quality for an institution like a hospital or provider groups. They are just that: individual measures. And they may not be that great. We are finding that they don't distinguish care sufficiently across providers in Massachusetts. So, you know, we will post data that shows that everybody is doing okay.

And what do we do with that type of information? As we have come together in the state, all of our public purchases, Medicaid, our state employee program, the Connector, we are looking at our purchasing power to try to implement reforms in the way we pay for services to define value. But we can agree on a few things, but

we understand that that doesn't necessarily represent overall quality.

Chairman STARK. Thank you. Thank you all very much. Mr. Camp, would you like to inquire?

Mr. CAMP. Well, thank you, Mr. Chairman. Dr. Lewin mentioned, certainly with self-employed people, they don't have access to employer-provided care, and that there might be something we could do there.

Mr. Haislmaier, is there a way to have, you know, an individual consumer policy available, and not erode the employer-provided care that most—that 85 percent of Americans have?

Mr. HAISLMAIER. Yes, I believe there is. And that is sort of the core of the insurance market reforms that I worked with, with the then-commissioner of insurance under Mayor Williams here, in the District of Columbia. And the advantage was, of course, that when we tried to work out the details of how a state regulating insurance would interact with Federal law, we just got in a cab and went and saw the Department of Labor, or Department of Treasury. And that basic design was what was incorporated in the Massachusetts reform, we shared that with them at the time they were developing it. And I have since then—in working with other states—made refinements to it.

The analogy, really, is to what we did with 401(k)'s in the pension area. In other words, instead of presuming that every small business could run a defined benefit pension plan, where you work 30 years and then you get so much, and the business has to invest it and all, you create a system within the context of employer offering, and all the advantages of that, where people have an account and they invest in it and they take the money with them from job to job.

That is what the Connector is designed to do. That part has not entirely come online in Massachusetts. They have only done that, so far, for the part-time and temporary workers, and for the individual market. But they're working toward—based on discussions I have had with the Connector leadership—they are working toward a goal of this fall, bringing online the ability of a business to simply go there and say, "This is my employer plan. What does my employer plan consist of? It consists of this menu of 40 different options in the Connector. My insurance agent will sit there with you, as a benefits counselor, to figure out with you what's best for you, and help you pick a plan."

Now, that has all the protections—guaranteed issue, et cetera—of Federal law, with respect to employer coverage. It all qualifies as tax free. But the individual owns the policy, and can take it with him to the next job.

So that's, essentially, the design. And I see that that is sort of the first step in insurance market reform that a number of states are looking at. Massachusetts went a little further, in also including their individual market. In some other states, that may take some time, because some of the issues are a bit more contentious.

Mr. CAMP. Well, thank you. And, Mr. Weil, you mentioned in a study you wrote or co-authored that one function would be for state government to provide a well-functioning market. And what are some of the things you envision in a well-functioning market, and

how does that differ from what we currently have, and what reforms might be included in that?

Mr. WEIL. I think we can all agree that providing employees with more of a choice of plan would be a benefit to most of them. Whether it would really drive these broad reforms in the health care system is more uncertain. But it is the case that most employees do not get a choice of plan; most employers pick a single plan, or a number of variants from the same carrier.

But there is an infrastructure there that the employer provides that needs to reside somewhere if it leaves the employer. I know, in my small business, it may be a non-profit business, but we spend a lot of time helping our employees navigate their insurance product. And we only have 1 of them; imagine if there were 100 of them to choose from. Someone still needs to play that role.

I think the real issue in regulating the market is a series of policy choices regarding pricing and availability. There are many states in which the small group market—and most states in which the individual market—has fairly liberal rules with respect to the insurance industry practices regarding rating up the policies of those who are older, those who may have an illness, those who——

Mr. CAMP. Well, would you allow individuals to buy insurance products across state lines?

Mr. WEIL. Would I? No, I would not do that. And the reason, Congressman——

Mr. CAMP. It would be a bigger pool, for example, for all the Realtors that are out there, or contractors that are involved——

Mr. WEIL. It would——

Mr. CAMP [continuing]. In some association.

Mr. WEIL. The concern—I think it's a very rich topic for discussion, and I certainly don't suggest my own views are the only you should hear, but my sense of the problem with going across state lines is that there are pooling rules within each state. And the moment I, if I lived in Massachusetts, can buy my product from the unregulated state next door, then the pool that you've created to create an affordable system in Massachusetts unravels, as the low-cost folks purchase across lines in a state that doesn't' community-rate, and gives them a cheap product.

So, all the consumer protection issues aside, which I think are very large, from a simple pooling perspective, allowing purchase across state lines unravels any effort to create larger pools of cross-subsidy within a state. And that means we will all purchase our own insurance. Our own prices that we will face will be those of the risk profile of ourselves. Older and sicker people will, by definition, pay more because younger and healthier people will find a state where they can buy a product that is priced at their low cost.

So—and I think that is a dramatic policy choice for the nation, as a whole, to say that a state like Massachusetts cannot create a single pool across which all residents of that state will make contributions.

Mr. CAMP. Well, I see my time has expired. Thank you all for being here. Thank you all for all the hard work you are doing, and for your testimony this morning. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. Doggett.

Mr. DOGGETT. Thanks very much for your insightful testimony. Secretary Bigby, in your state, you gave the responsibility, or the legislature gave the responsibility, of giving meaning to terms like "affordable," "minimal credible service," "reasonably comprehensive" to a board, rather than having the legislative body try to define all aspects of that.

At the Federal level, is that the best approach? And perhaps you might have some thoughts, as well, on the concept of a board modeled on the Federal Reserve, such as that that former Senator Daschle has recommended.

Dr. BIGBY. Yes, I think that's a very good question. I am—I will say that I think the legislature realized that they could never come to agreement on what the definition of minimal credible coverage was, or what affordability might be. And so they did give this responsibility to the Connector board.

I think that the composition of the board was very thoughtful, in terms of who is represented: the type of knowledgeable people that are there, but also those who represent consumers and can advocate for them. So I think that the concept of that type of board that has the authority to do that was an excellent thing. And I think it could be done at the national level.

Mr. DOGGETT. You have managed, in Massachusetts, to reduce the number of uninsured citizens significantly over a relatively short period of time. At this point, what do you think are the most important steps we need to take at the Federal level, to ensure that the job is complete, and that you achieve universal coverage for all your citizens?

Dr. BIGBY. Well, I think that the components of health care reform that allowed this progress to occur are still what we would like to have in place. Many of those components are there because we had partnership with the Federal Government in our Medicaid waiver.

I think that the ability to expand coverage to low-income people was very important. When we look at who has benefited the most from health care reform, and where we have seen the highest increase in insured populations, it's among low-income individuals and young men, who tended not to get insurance, even if they could afford it.

I think that those principles of insuring people and using resources, as has already been mentioned, that had been going to institutions is very important for insuring that we're covering individuals, and that is very important.

In the long term, we know that we have to do better at containing costs, so that we can continue to sustain this. And I think that the mechanisms that we have for doing that will require just as much creativity as the things that we put together to ensure access. So, flexibility around payment system reform, value-based purchasing is also very important.

Mr. DOGGETT. Ms. Riley, next door, in Maine, you have encountered, I think, some of the same problems trying to contain cost that we have, and, in fact, are battling over this very day, as we attempt to eliminate the incredible waste of unnecessary subsidies in the Medicare program, despite its defenders in the White House, and some here, unfortunately, in Congress.

As you look back over your experience, I am sure that any health care reform will encounter significant opposition. But are there things in the cost containment area that you would do differently, or recommend that we approach differently, here at the Federal level?

Ms. RILEY. That is a very tough question.

Mr. DOGGETT. It is.

Ms. RILEY. I think that, clearly, when health care is a seventh of the economy—it's one in six jobs in Maine—somebody's idea of cost containment is another person's salary. So it is, obviously, very difficult.

I think it is absolutely incumbent on us to get the stakeholders around the table, and to get a vested interest in cost containment.

We initially tried to do a global budget with our hospitals. It was highly unsuccessful, and fought viciously. But that was replaced by voluntary hospital targets at the meeting.

We have created a Maine quality forum to look at the national data, and eliminate the variation that exists, pretty dramatically, in our state. And I think that that has been a fairly successful approach. And we have instituted medical loss ratios in a small group in individual market to do those kinds of protections.

But, in the end, I think it is—the notion of a global budget, the notion of everybody coming together and negotiating around the inefficiencies of the system to find ways to solve—to get those inefficiencies out of the system and reinvest them makes lots of sense. It has been a very challenging situation for us, and I think, in part, because the financing was precedential.

So, one of the problems I think we face as states is, as long as states are viewed as laboratory experiments, and they're not policy, then the reaction to people is to fight them, not to fix them. And I think Alan's point is quite right, that we need a sustainable federal policy that says we're keeping our feet to the fire, everybody has to work on this and get it right. Then I think we can get the right incentives around cost containment.

Mr. DOGGETT. Thank you very much.

Chairman STARK. Mr. Thompson, would you like to inquire?

Mr. THOMPSON. Thank you, Mr. Chairman. Thank you for holding this hearing, and thanks to all the witnesses for being here.

I would like to know if any of you, in your work with the different states, and your efforts to try and move the states' health population ahead, have run into any barriers in regard to ERISA. Have there been things that you couldn't accomplish, or have there been ERISA exemptions that got into the way of providing for a healthier community? Jack?

Dr. LEWIN. Sure. I think that—well, you know, obviously, Hawaii couldn't proceed—you know, the courts—throughout their law, because it was deemed to have violated ERISA, and we had to get this ERISA exemption from Congress. The exemption is a frozen exemption. It's—the provision of the whole law are in there, and Hawaii is fearful of ever coming back and asking for any amendment.

So, you know, the cost split between the employer and employee was set for what the costs were then. Costs have gone way up, and

the employee's cost remains one-and-a-half percent of wage, which is woefully low, and it's unfair to the employer. So that's a destabilizer there.

When we went back in to do a program for the unemployed, self-employed, part-time employed, the state health insurance program, we had to make that—we wanted to try to get everybody covered, but we ran into ERISA barriers with that.

And, in California, as we tried to proceed with SB–2, we also had—knew that when—you know, if a law didn't make it through the challenge of the public ballot initiative led by Governor Schwarzenegger, we would have been challenged on the basis of ERISA at some point in the future.

So, yes. I think every reform has to dance around ERISA in order to try to get more people covered.

Ms. RILEY. And I think, conversely, any time we talk about mandates, employer mandates, or employer requirements, we are always—there is always a balancing act about when we're going to force employers into the self-insured mode, and away from the protections of state regulation. And that's a balancing act at the state level.

ERISA, at is most narrow, though, is critically important to—basic to Chairman Stark's concern about quality and data. ERISA prevents us from requiring self-insured plans to contribute data to our all-payer database. So it's very hard to sort of move to a meaningful quality initiative or cost initiative without the ability to get that data from self-insured companies.

Dr. BIGBY. In Massachusetts, in May, we issued a report where we looked at employers who had 50 or more employees on state-subsidized health insurance. And that totaled $636 million. These are mostly part-time workers, or temporary workers, or people in the waiting period before their insurance takes effect.

And when we talked to employers about changing their policies that would decrease these numbers, the whole issue of ERISA came up at that time.

Mr. HAISLMAIER. Mr. Thompson, a couple of things that I would add to my colleagues here, on the data usage, in particular. Yes, ERISA provides obstacles to certain things. I am not necessarily convinced that that's a bad thing. I mean requiring every pizza joint to operate a defined pension plan—like a defined benefit pension plan like GM—is not necessarily a good thing. Similarly, requiring employers to buy and manage the insurance isn't necessarily a good thing.

But there are a couple of points. One is—and this is an area I am looking closer at, in both Federal law and ERISA, and also state law, with respect to insurance—is the possible obstacles to plans offering subscribers rebates for successfully completing or participating in disease management.

I think the problem we see with a lot of the wellness stuff is that employers don't feel that they can selectively say, "Well, okay, you have diabetes, and if you participate in this program, then we reward you at the end for your success." Employers feel that they would fall under discrimination statutes in that case.

And so, instead, they say, "Well, here is membership to a gym." Well, that doesn't seem to produce much in the way of improve-

ments. So that is a big of an obstacle. In the states, there is a corresponding obstacle that I am looking into where those kinds of rebates under some state laws could be seen as an improper inducement to coverage. So, that's an area.

The other area I would touch on is I think that a large part of—and I have a paper coming out on this shortly; in fact, I will be editing it when I get back—what has to be dealt with is the concept of how you risk adjust within any system. And in effect, I think that the easier way to do that is with a back-end sort of claims pool, where you put all the high-risk claims in a pool, and then redistribute the money across all the covered individuals, so everybody pays a little extra on their premium. The problem is, you can't include ERISA plans in that.

Mr. WEIL. Mr. Thompson, could I add one last item to this very, very complete list?

Mr. THOMPSON. You have to ask the chair; my time is over.

Chairman STARK. Go right ahead.

Mr. WEIL. This has been a terrific list of the impediments. I would add only one, which is there is growing interest in programs called premium assistance, where you blend public dollars with employer dollars for those who have an offer of coverage at work. And there are a lot of complications around those plans.

But one of the barriers ERISA poses is you cannot mandate the participation or even the sharing of information by employers that might make it possible to determine whether that was a viable option.

Chairman STARK. Thank you. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. Thank you, Mr. Chairman. I want to commend you for this hearing, and this absolutely superb panel. I used to be a state insurance commissioner, it's been my privilege to work on these matters with some of you for a long, long time. The issues are still very much with us.

What I think some of the state innovation has done—and I chaired, or was part of, an effort to create the second or third state high-risk health pool back in my state legislator days of the 1981 interim we passed in 1983. And it did provide a guaranteed mechanism for high-risk folks that could otherwise not get coverage to obtain coverage.

On the other hand, we did nothing—we didn't address cost at all. The premium was 125 percent of average individual policy, and it really has been out of reach of most people, which gets to the crux of my question.

If health reform continues to just deal with the financial intermediary range of issues, we're missing the underlying cause of the whole problem. That is, costs are getting away from us. We pay double per capita than any other country pays in the world. We are not getting an outcome that would reflect that additional investment.

Indeed, if you look at Medicare data within our country, you've got areas of—the higher cost areas are getting the worst results, the lower cost areas are getting the best results. And we really need to get pretty darn serious about this, because literally, hun-

dreds of billions of dollars of Federal moneys are going into these expensive areas, not giving us best results.

So, value medicine—not meaning medicine on the cheap, not meaning inferior medicine, but value medicine. This is a concept that I really think has to come to the fore of our health reform discussions. I would like to go down the panel and just hear your thoughts about how we advance the notion of getting better value out of our care delivery system. Well, I will continue on for a moment to give a little more direction on the question.

As we look at value medicine and health reform, maybe we ought to look at more ways we build, you know, not just state response to insurance, but state-supported delivery systems. And we've done a bit of this: community health centers. What is your view of the role that they're playing, in terms of cost-effectively getting broader access to some care to people that otherwise don't have coverage?

School nurses. Is this a meaningful components of getting, you know, universal screening out that—to children, where it might have tremendous preventative impact and cost savings that would result?

Is there ways that Medicare reimbursements can be rejiggered to provide greater incentive to integrate systems, and elevate primary care as a principal component of Medicare care delivery? Those are issues I am thinking about, and I would be very interested in the panel's responses. Thank you.

Mr. HAISLMAIER. Thank you. At the risk of taking away from Secretary Bigby, I would like to actually talk about some of the things going on in Massachusetts, because that provides an example.

I actually had the opportunity at another conference earlier last week to share the panel with a woman who is the CEO of the hospital in Concorde, Massachusetts. And some of the discussion was around this. And some interesting things are happening in Massachusetts.

As Secretary Bigby noted in her example of the dry cleaner, people are now, with the coverage, getting primary care. They have suddenly woken up in the state and realized, "Well, we have a shortage of primary care providers," which is something that us health policy people have been talking about for years and years, and now they're having to do something about it.

What's interesting is CVS is opening up minute clinics there, in Massachusetts. And what I found really interesting was when this woman who runs this hospital was discussing this on the panel, she said, "You know, my primary care providers don't have a problem with that. In fact, they like that, because more and more people are getting the minor stuff seen to, and their time is available for the more complicated."

So, contrary to what one might think—that there is a clash of interest—actually no, it's working out. But what's happening is that the intermediaries are seeing that they now work for the patient, not the employer. And that is my second point, and I will use the illustration of Massachusetts, as well.

We call employers payers, but payers—and the government is one, as well—care about three things in the system: cost, cost, and

cost. So, when the intermediary works for the payer, the question is, "How do I control the cost?"

Well, there are lots of ways to control costs. In fact, some of the easiest ones are ones that don't benefit the patient: make it difficult for people to get care, pay the doctors and hospitals less. The most effective way to control costs is don't pay.

Now, Massachusetts is about to have a situation where an employer, instead of having the insurance company work for them and their choice of insurer entirely based on, well, how low is your premium, they are going to be able, soon, to give their employees the option of going to the Connector and picking a plan.

If you go to the Massachusetts Connector in that scenario, and you pick a plan, and you look at the lowest cost plan, and you ask them why are they the lowest cost, and the answer is, "Well, because when you get sick we make it difficult for you to get medical care, and we only send you the providers that take very low reimbursement," I think you're likely to move on to somebody whose answer is, "Well, you know what? We have taken all the data we already have, and we have figured out which providers give the best results at the best price, and you can go to any provider. But based on this tier—and here is the data—these are the ones you get a lower copay for, and these are the ones you get charged more for."

Ms. RILEY. Thank you. It's good to see you again. I think that the variation issue is particularly frustrating, because Winberg's work has been out there for 20 years, and we have taken very little action on it.

In Maine, we have created the Maine Quality Forum, whose focus is to look at variation, work with the providers, and, because you can see a tenfold difference for the same person getting the same treatment in Maine's hospitals and in every hospital in the country, so that the Maine Quality Forum will work with providers to bring that variation down, starting in a voluntary way. And I think, over time, we will have to connect prices with that.

The issue of community health centers and school health centers and so forth is all very intriguing. But I think what McKinsey tells us and most of the studies show is it is the fragmentation of our system that causes much of its cost. So, while those are extraordinarily important services, how do they connect together, and create a system of care, so that we don't have redundancies that are terribly, terribly costly. And I think we have not been as thoughtful about that as we ought to be.

And, in fact, when you think about Federalism, the Federally qualified health centers and community health centers have a direct Federal relation, but none to the state. So the state, just like a self-insured plan, the state can't ask a Federally qualified health center to do something specific as part of a plan. And I think that's a question in Federalism that ought to be looked at.

But I do think the big issue of the fragmentation of our system is a cost driver. The Federal Government, as a huge purchaser of care—Medicare, Medicaid, Federal employee health benefit CHAMPUS—could set the same standards, could set—could determine prices, could determine ranges of prices. Because what we know is we pay more and we have more.

In Maine, we decided to address the supply question. We have a certificate of need program, but added to that a capital investment fund that was a budget for new capital that said we will have all the capital we need but not more, because we recognized that supply, in fact, in this country drives demand.

And finally, I think if we could look a little at Medicare and Medicaid, one of the big cost concerns in the states is always the allegation that the public programs underpay. And they do. But I think there is a middle ground. How much do the public programs underpay, and how much is the price and cost too high?

But the notion of the cost shift is a problem in the system. And we need better data to know—we don't have comparable data state to state to state about what Medicaid pays, or have a good system of looking at what Medicare pays. In a rural state like ours, the wage index isn't adjusted. And so, we are actually discriminated against in Medicare, and don't get—even though we have to compete nationally.

But I think your question begs a bigger issue about what kind of Federal reform we want. I*t may well be that we need to think very differently. It may well be that what we need—as we talk about the primary care crisis in America, we are now talking about reinventing primary care through something called an advance medical home. Very good idea, but it has become the new sort of silver bullet.

And I think maybe we should rethink. Maybe there ought to be a rethinking of our health care system, where you have a publicly supported, primary care preventative program that is mandatory for all Americans and we take our public health funds and we work with primary care physicians, and then you insure just those things that are insurable events—sickness—but require insurance companies to guarantee issue, to make sure everybody gets access to it. It may be time to really fundamentally think differently about how health care is provided.

Chairman STARK. Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman, and thanks to our panelists. And, Dr. Lewin, great to see you again.

Dr. LEWIN. Great to see you.

Mr. BECERRA. Let me ask a quick question. It appears that the President today is prepared to veto legislation that the congress passed—both the House and the Senate—with overwhelming numbers to try to stave off a cut to doctor reimbursement rates, which, in many quarters of the country we're hearing, are necessary in order for some of these physicians and providers to continue to provide medical services to Medicare beneficiaries—most of our seniors 65 and over.

I am wondering if you can tell me: I know we're talking more globally, more universally, in terms of coverage for health care, but what could be the impact if the President's veto—well, first, if the President were to veto; and secondly, if the veto were to stand on this cut, or staving off the cut of 10 percent to health care providers. Dr. Lewin?

Dr. LEWIN. Sure. Well, I think it could be significant. I think that, for primary care physicians, and for rural physicians, and inner-city physicians who—the viability issue is very, very real.

And I think you can't—it's not like a starve the beast, you know, philosophy that is going to work here. So I think that is—it's very damaging.

And it also has kept many of the health policy people in the physician community, and among the health care professions together, away from the topic of quality for 7 years. We just keep fighting this same repetitive battle. We are treading water and going nowhere, and I think it's time to get over that.

I—going back to Mr. Pomeroy's questions about quality, you know, putting on my cardiology hat, 43 percent of Medicare costs are cardiovascular. A lot of that is preventable. If we don't work on preventing people in the pipeline from needing the services, we are all going to bankrupt the system, just on cardio-vascular care, alone.

But when you get to the care that is needed today, we are not very efficiently spending our resources. I mean, we really could do a much better job with the dollars we have at producing more health by using information, the tools we have before us right—today, to shine light on who is doing a better job.

When we, last year, looked at all the hospitals in America, and used our registries, the cardio-vascular registries we have up across the country, to say how much time—and we have these registries in just about every large hospital today, measuring outcomes in cardio-vascular medicine—we looked at how much time it took to get from the emergency room, when you're having a frank heart attack, to getting the blocked coronary artery unplugged.

We note, from the science, that if you take longer than 90 minutes, that the muscle tissue behind that blockage doesn't recover, it becomes a scar, putting you at risk for heart failure and enormous cost in the future.

Every hospital in the country, all the major centers, said, "We do this in less than an hour." But when we measured it, we weren't doing it in an hour, we were doing it in 2 hours, in two-and-a-half hours. In 1 year, just by giving people the information, just about every hospital in America has gotten their time down under 90 minutes, where it needs to be.

Getting information to doctors and nurses and teams about how we're doing in hospitals is something we could do today, and it would not only eliminate disparities, it would get rid of variation, and it would give people—because nobody wants to be conspicuously, you know, spending more or doing less than what's appropriate.

Even at the individual care team or physician, you can measure adherence to guidelines and performance measures, and the standards we have today. We need more of those. But we could measure those today and determine very accurately, for every care team and physician, whether people are getting the best evidence-based medicine.

That ought to be our goal. We could get to that so inexpensively, that I think that—and so the physician reform in the SGR doesn't do any of that really, and there has been some movement on the——

Mr. BECERRA. Let me ask Dr. Bigby and Ms. Riley to respond, because you have to run these state programs. And if, at the Fed-

eral level, we are sending down cuts to some of these providers who are saying, "We are going to possibly get out of the system, at least for Medicare," I imagine that throws your systems out of whack a bit, as well.

Dr. BIGBY. Yes. Somebody has already raised the issue of cost shifting, and it's something that we contend with every day.

You know, I think that the issue of what Medicare rates are for different providers is a very important one. There are things that Medicare does not pay sufficiently. There are things that they pay probably more than they should. Without a conversation about looking at that dynamic, and simply cutting rates across the board, you just exacerbate a problem that already exists.

Mr. BECERRA. Ms. Riley.

Ms. RILEY. Well, as the oldest state in the nation, we watch very carefully the work on Medicare, and are quite concerned. Obviously, when Medicare cuts, somebody pays. And that is cost-shifted to premium payers.

And we are also a state of very small businesses who just can't afford to see their costs grow. So we wish you good luck.

Mr. BECERRA. Yes. And I see my time has expired.

Chairman STARK. Well, I just wanted to ask Dr. Lewin if he didn't think U.S. News and World Report was enough. You want more information than that?

Ms. Schwartz, would you like to inquire?

Ms. SCHWARTZ. Thank you, Mr. Chairman, and thank you for the opportunity to participate in this hearing.

And I wanted to just follow up on a couple of things. First, I did want to thank the panel for acknowledging the good work of the Federal-state partnership and the public-private partnership on SCHIP. I was involved in Pennsylvania in 1992, 5 years before the Federal level, and we have done a remarkable job, I think, across this country to do more, as you know. We have pushed for that. And hopefully we will be able to—under a new President—be able to do that.

And I did want to also acknowledge the point that was made about prescribing and the use of health IT. I think, Dr. Lewin, you mentioned that. And should we override the President's veto on the Medicare bill,we will actually move all physicians under Medicare to e-prescribing. So thank you for—physicians, and actually all players—helping in getting that done.

And I will continue to do work on health IT. I think the discussion we have had about quality and measurement and fragmentation—I think that, Ms. Riley, you mentioned that—all or many of those issues could be, at least in part, addressed by health IT and linking all of our providers in this country. So, thank you for your comments.

What I wanted to address today is the role of market reforms in reaching all Americans, being able to make sure that all Americans do get access to universal coverage. I think our Chairman reflected that because about 50 or 60 percent of Americans have employer-based coverage, we are likely to keep that system going forward.

But as a number of you pointed out, there are major obstacles, ERISA being one. But there are other market issues in both the individual marketplace and the small group market. And, of course,

access to the larger employers, because of the obstacles from ERISA are major issues.

And will raise just—I would like you to really—my question is whether you could really elaborate—and some of you have done this—but even more on what are some of the essential market reforms, and the role we would play, at the Federal level, so that these market reforms don't happen—so they happen individually in every state, that the disparity between the states and what mandates at the state level—I actually got a lot of mandates down on women's health, in particular, so I guess women were not at the table when the insurers decided what they wouldn't cover or not, so we did some of that.

But, first of all, I have a bill to exclude—to prohibit the use of some of the pre-existing condition exclusions for children. You know, just the very fact that parents may actually have their insurance lapse, and then they sign up for insurance, trying to do the responsible thing, and they are told, "I am sorry, your child might be a diabetic, but you haven't had insurance, you have to wait six months."

Now, my guess is that if that child doesn't get help, it's pretty bad for that child. But then they are more likely get uncompensated care, help, somewhere, and probably the most expensive way possible. I think this is unconscionable, that we have children in this country to whom insurance companies apply pre-existing condition exclusions.

But there are waiting periods, again, and your employer can say, "I am sorry, I would cover you, but you have to wait 6 months to get coverage, because I'm not sure you're really going to be with us that long." We have employees who don't sign up for insurance—because they forgot or because they were busy when they were new employees—and then they want to sign up and the employer says, "I'm sorry, you didn't sign up in the first 3 months, you have to wait for some change in status, like you have to get divorced or married or something to make a change," because again, all—so many of the rules are set up to ensure that our insurance companies don't cover people who are sick.

Now, I understand that. They want to be risk-averse. But it has worked against even those who have access to insurance, to not be able to get meaningful insurance coverage. And so really, the issue here, of course, for many of us is not just about getting all Americans covered, but to make sure that they sign up for it, and it means something to them.

So, if you could speak more specifically, I have raised several of the issues around market reforms. But my concern is that, however we go in terms of national reform, to not look at these market issues for those who have access to insurance or don't. And, of course, one of our nominees for President says we should throw everyone into the individual marketplace. Well, without market reforms, it's going to be completely meaningless for Americans—too expensive, and not mean anything once you buy it.

So, I'm sorry. Long question, but it is not a small area, to really look at not only the role of ERISA, but the role of the Federal Government in what is now a state-regulated system of insurance, health insurance, that makes it completely—again, fragmented, if

you want not just the delivery system, but the insurance system, so that Americans don't know that, even when they're buying it, or when they get insurance, that it's going to cover the health needs that they have.

So, let's see if we can steal a couple of minutes and have—if we could start maybe at the top, or whoever wants to really address some of these issues. And it is a larger conversation going forward, I know, but I would appreciate your input.

Mr. WEIL. As you note, the insurance regulation primarily is at the state level. And I think when the Federal Government steps in, it should do so with some caution. But it has done so in critical areas, and I think it is appropriate to do so in those critical areas.

I don't think anyone would benefit from a complete Federal takeover of the entire system of regulation. And as I responded to Mr. Camp earlier, I do worry about the crossing of state lines.

Really, I think the primary caution I would make is one, Congresswoman, very similar to the point you made, which is that the real Federal issue is don't imagine that a Federal policy shifts more people into state insurance markets, particularly individual markets, that you know what you will get for that investment unless you have some Federal standards with respect to what insurance is going to look like.

Because the degree of variability around the country in those markets is so great, a Federal policy designed intentionally to move people into those markets will have very different consequences in different states, just as a uniform tax credit at the national level would mean something very different in different states. Because if you have rating rules that are community-rated, then that credit will go an equal distance in providing coverage for everyone in the state.

But if you have age or health status rating, a uniform credit will be insufficient for other people. It's not that that——

Mr. CAMP. Will the gentleman——

Mr. WEIL. I will—just one sentence, sorry, which is that it's not that these issues can't be overcome, it's simply that they should be attended to, as you are considering the Federal role.

Mr. CAMP. But association health plans wouldn't be individuals. So they would be involved in nationwide plans, not necessarily in individual policy, but in association policy, which would have a totally different effect, wouldn't you agree, than——

Mr. WEIL. Absolutely. Associations are very different from individuals purchasing across lines.

Mr. CAMP. Okay.

Ms. SCHWARTZ. Right. And, Dr. Bigby, if we can indulge——

Chairman STARK. Well, why don't we let Dr. McDermott inquire, and then we can go around and get more——

Chairman STARK. Thank you, Mr. Chairman. Thank you for your indulgence.

Dr. MCDERMOTT. Thank you, Mr. Chairman. Nothing is going to happen in the congress that doesn't solve the problems of New York, Florida, Texas, and California. They are not here today, except a little bit of California.

Chairman STARK. Hear, hear.

Dr. MCDERMOTT. I come from the efficient part of the medical delivery system in this country. Minnesota, Washington, and Oregon operate way below per person costs of any place in the United States.

And it has struck me that the biggest problem we're going to have in this place is do—if we take some way of getting everybody in, we're going to bring everybody up to California, or everybody up to New York, or everybody up to Boston?

Now, the average cost—last year we spent $2.1 trillion in this country on health care. That is $7,000 per person for the country. How—would you, in Massachusetts, and you, in Maine, take $7,000 for everybody? If you were guaranteed that amount of money, could you deliver health care to your people?

Dr. BIGBY. Absolutely.

*Ms. Riley. Maine is one of the most expensive states. Massachusetts is the most expensive, and we are second. I would love to take on the challenge, but I'm very nervous about it, in the same ways that Maine—unlike Massachusetts, which had significant Medicaid money to fund its reforms, Vermont accepted a block grant-like entity, and we were unwilling to go there.

I think the worry we have when we move from an entitlement nature in Medicaid programs and others is that we're moving away from universal coverage as we move away from entitlement. So I would worry about a block grant approach in its capacity to meet everyone.

But if we were talking about a reform that set a framework for national expectations, and set a framework for the——

Dr. MCDERMOTT. If we design a system, are we going to go to an average for the country, or are we going to go to—we're going to keep recognizing these huge disparities we have today?

Ms. RILEY. Oh, I think——

Dr. MCDERMOTT. Is that what you're saying?

Ms. RILEY. I think I——

Dr. MCDERMOTT. We should let Maine be an outlier?

Ms. RILEY. I would love not to be an outlier. But I think the key here is to create the right incentives, though, to make sure that the funding, if it's capped, comes at the expense of inefficiency, and not at the expense of coverage.

The worry I have—as you watch some of these reforms, the question is always—needs to be asked, what is coverage? Because increasing—it's—is it real coverage if we give somebody just a bare bones plan? I would argue no.

Dr. MCDERMOTT. Okay. Let me give you another thing to chew on——

Dr. BIGBY. Can I just——

Dr. MCDERMOTT [continuing]. Because I think you—this whole panel has talked, and not one single word has been said about workforce. Not one single word about workforce as the driver of costs.

Now, I'm a physician, so I know. I got out of medical school $500 in debt. But the kids coming out of the University of Washington today are $150,000 in debt, at a minimum, which drives the way they practice medicine.

I would suggest that one of the things that's got to happen in this country is that state medical schools have to become free, and require 4 years of service in underserved areas within the state for you ever to get the kind of people that you need in the rural areas and the underserved areas in the country.

I cannot see how you're ever going to have people not want to have a residency at Bent Brigham for ophthalmology or gynecology or whatever, if they're $150,000 in debt. If they have been guaranteed a free education, they could then be sent out someplace. Or, in Minnesota or in Maine, the same thing. I don't know how you're ever going to get the primary practitioners you're going to need to deal with it.

Dr. BIGBY. I would argue that it isn't just state medical schools who might subsidize that type of service, but the Federal Government is already subsidizing——

Dr. MCDERMOTT. No, they are to—a little bit.

Dr. BIGBY [continuing]. To the training of the specialists that we are producing. I think you are——

Dr. MCDERMOTT. Yes, but not to the ones at the primary level. We're not subsidizing them at all.

Dr. BIGBY. And that is part of the problem. We get what we pay for.

Dr. MCDERMOTT. Yes, we do. And I think that this argument about what—about quality and all the rest of it, until we deal with the fact that we, by the way we train and make kids go into debt—because I was a poor kid, I didn't get anything from my family. The State of Illinois educated me, and the day I left—or the day I graduated, I left and never left anything on the table for the state of Illinois.

Now, I think there is some social responsibility that has to go into state medical education. That's why I pick on state medical schools. Harvard can do what it wants, or Tufts, or all the rest of the schools, all the New York schools can do whatever they want. But the state schools should be producing, they should be investing. The state—people in the state are investing in these doctors, but they don't get the benefit of them.

Dr. LEWIN. Maybe the states and the Federal Government together could work on even a loan forgiveness program that would incentivize more and more people to lead in primary care, and then some of those people would enjoy that primary care and stay in the primary care area.

We do have all those—you know, the issue of whether the folks would wait until through their residency period. I mean, you know, cardiology, it's almost eight years, you know. It's after medical school by the time most people are out. And so that would be a long wait before they went to the rural area.

Dr. BIGBY. I do think that the issue of workforce is very important. But it's also in the context of the way we practice medicine today.

I am a former primary care physician, so I can say this. If we think about 25 years ago, what we knew about the management of chronic illness that many primary care physicians are caring for, there wasn't really a lot that we could do for people. In 25 years, that knowledge has grown exponentially, and we have a much bet-

ter understanding of the value of prevention, of secondary prevention, of intervention to avoid the complications of diabetes and high blood pressure.

But we still pay people the same way to take care of those problems every 15-minute visit. And we don't support the teams that we know are important to help patients understand those illnesses—so, nurses, health educators, case managers.

So, if we are going to attract people into primary care, it's not just about paying them more, or obligating them if they come from a state school, but actually supporting the type of practice that they want and that their patients want.

Dr. MCDERMOTT. Mr. Chairman, could I just tell a short story?

My mother-in-law had a hypoglycemic experience in Seventh Crow Wing, Minnesota. Now, this is the boondocks, let me tell you. It is way far north. The nearest medical facility of any size is Fargo, North Dakota. So they took her over to Park Rapids, to the little hospital, and they dealt with her there. And they said, "You know, we can't handle this here. You've got to go to U of M, or you've got to go to Mayo." And she went down there.

Now, they have figured out a complicated system to deal—and she had an insulinoma on the tail of a pancreas, so she was having serious problems, had surgery, and is back up in Seventh Crow Wing today.

Now, if you can do that in a state and do it for so much less than New York or Boston or Los Angeles, or these other places, how do you—how do we, as Congressmen—or do we just say, "Well"—we just go the California way?

Mr. HAISLMAIER. Mr. Chairman, if I could answer, I have been anxious to answer Mr. McDermott's question here, because I have encountered this situation. I did sort of touch on that when I talked about the increase in visits to primary care in Massachusetts, and the creation of minute clinics in CVS, which are open in the evenings, when people need them, as opposed to a doctor's office.

A couple of points. One, when you look at the emergency room data on who uses the ED, what you find is that Medicaid patients are using the ED at twice the rates of the uninsured, at twice the rates of Medicare patients, and at four times the rates of the privately insured. So if you get, as Massachusetts is trying to do, these folks out of the ED and into primary care, well, first of all, you've got more money to pay people in primary care. And so, you know, if you get what you pay, as somebody says, you will have a demand there.

The other point that I wanted to make directly addressing your question is I encountered this in Louisiana, where the charity hospital that they were using to train physicians at LSU was washed out. And I had this conversation with Dr. Hollier, the chancellor to the LSU medical school, and I went looking for a model, and I found one. And it exists. And it is in Utah.

And what Utah did is they got a waiver from the Federal Government—this is when Secretary Levitt was Governor—they got a waiver from the Federal Government to put their Medicare GME money—both the DME and the IME—in other words, both the direct medical education funding and the indirect—into one pot under the control of the state, combined with their Medicaid money

and what they have privately. And that allows them to have the dollars follow the residents.

That enables the state to do a workforce plan—you can go online and find all of this stuff, it's up and running—where they say, "This is the mix of providers we want." For example, "We want more primary, less orthopedists. This is what we will fund, and this is where we will fund it," so they get them out into those rural areas. I use that as an example of the kind of tools that I stumble across, and then share with other states.

So, for example, when I spoke with Dr. Jones at the University of Mississippi, he was very keen on this idea of maybe, as part of reform in Mississippi, you could use this as a tool to get more doctors in the Delta, doing primary care.

Now, from a congressional point of view, your issue is that you, in this Committee, are running a Medicare payment system where it's structured so that the money goes to institutions because, well, these are the institutions that have always done it, as opposed to saying, "No, the money goes into the pot, and the state can allocate those dollars for the kind of residents it wants, and where it wants them."

So, I would come back to you and say that is something for this Committee to think about. In the interim, I am going to be talking to these other states about, "What can you learn from how Utah did it, and maybe do it in your state with a waiver."

Dr. MCDERMOTT. Thank you.

Chairman STARK. Ms. Schwartz, I interrupted you when you were trying to survey the panel. And now that everybody has had a chance at least once, would you like to finish up on your——

Ms. SCHWARTZ. Mr. Chairman, I think that I appreciate the opportunity, but I think that the questions I raised will take a longer conversation than anyone might want to tolerate, given the hour. So I think I would just ask, if I may, that the panelists, should they have some ideas about some of the market reforms, particularly more specifically about our role not only in ERISA, but in terms of the other kinds of market reforms for individual and group, I would be very interested in following up after the panel and after this hearing.

So, thank you for the opportunity, but I will pass for the moment.

Chairman STARK. Mr. Camp, would you like to jump in here for a second?

Mr. CAMP. Thank you, Mr. Chairman. I don't have any further questions for the panel.

Chairman STARK. Okay.

Dr. MCDERMOTT. Mr. Chairman?

Chairman STARK. Yes?

Dr. MCDERMOTT. Could I——

Chairman STARK. Let me just follow up on yours for a minute, and then I will yield to you for more.

But you talked about costs. My guess is that, as you move westward, if you stay north, Hawaii probably has lower costs today than Oregon and Minnesota. I—maybe not. But I suspect there are very low costs.

Dr. LEWIN. Yes.

Chairman STARK. To what—why? Is that because you can't leave so easily, you have to——

Dr. LEWIN. Well, Mr. Chairman, I think a lot of things in Hawaii are very expensive. But health care has benefited by virtue of having everyone having access to primary care.

Chairman STARK. Well, wasn't it lower cost when you started?

Dr. LEWIN. Well, Hawaii's costs were—you know, Hawaii had a system, in agriculture, for example, of having community——

Chairman STARK. You had Kaiser.

Dr. LEWIN. They had clinics out there, they had Kaiser, and they had HMSA. So they had a two-payer system.

Chairman STARK. They had the right idea.

Dr. LEWIN. And they were ratcheting costs down, even then.

But also, Hawaii has benefited from universal primary care access. And a good safety net, as well, for—even for people that didn't fit into the employer mold. And that really made a big difference. I mean, Hawaii's data, for example, showed it had one of the highest incidences of breast cancer——

Chairman STARK. You're going to tell me that the universal health access for primary care——

Dr. LEWIN. Yes, because that was covered by the—when everybody got that primary care access out of the emergency room, that meant that——

Chairman STARK. When did they get that?

Dr. LEWIN [continuing]. They were diagnosed earlier and treated earlier.

Chairman STARK. When did they get the——

Dr. LEWIN. That happened in the early eighties, when the employer mandate became activated.

Chairman STARK. Okay. But I guess what I am saying is, prior to that time—at that time—weren't you a low-cost state then? I mean——

Dr. LEWIN. Well, we were a low-cost state for a number of reasons. But it wasn't because of genetic superiority, or everybody surfing every day. I mean, Hawaii had provided primary care to agricultural workers already, for example, and had done more in terms of building a safety net than a lot of states had done. And I think that contributes.

I have produced a few articles in the past that show that getting that access to primary care for everybody—something that most of the world has already learned—reduces all sorts of later costs, because you get people diagnosed earlier and treated earlier for things that end up, through an emergency room, being far more expensive and catastrophic.

And that is just, you know, a lesson that America hasn't picked up, but we certainly ought to soon.

Chairman STARK. Well, I think Ms. Riley touched on that idea, which I thought was very interesting.

Jim, I am sorry.

Dr. MCDERMOTT. Mr. Chairman, thank you. Another thing I was struck, listening to you, was you all want to keep the employer-based system in place, and fiddle with it around the edges, whatever people are talking about.

I remember a guy named Charlie Wilson once said, "As General Motors goes, so goes the United States." And General Motors, their bonds today are junk bonds. And it is largely because of their health care costs and their pension costs. And they are closing plants all over the place, and they are looking for a way to be more competitive. And they know they can't compete with Toyota if they keep that stuff in-house. They are trying to get rid of it, as is every airline in this country.

And I think that I—it seems to me you're hanging on to a sinking ship. Now, I would like to hear your response to that, because what do you see that seems to say—I heard Safeway, somebody mentioned Safeway as doing a good thing. But what else do you see that makes you think that the work, or the employer-based system, is going to survive?

Dr. LEWIN. Well, I guess my point there, Sir, was that if we destabilize the employer-based system without putting in place the access to care solution with a mandate behind it, so that many of those people who are currently covered by their employer end up uninsured, we would really do our Nation a great disservice.

So, if we were to shift to an individual mandate approach, or an individual coverage approach, and have a mandate in place, and then allow a gradual attrition to a new system, that might work quite well.

But I think that the concern I would have right now about moving too swiftly or sending a message to employers that you might as well—you can let go of this huge burden is that we end up with a lot of people who would not elect voluntarily to purchase their own coverage, and we have many, many more people in the emergency room and uninsured. So, I think we have got to be careful about destabilizing.

On the other hand——

Dr. MCDERMOTT. What about——

Dr. LEWIN [continuing]. Try to improve the employer coverage, and put it on a level playingfield with individual coverage, so that the individual could have portable benefits, could have all the same advantages, and then let people have an option and maybe let even some competition there exist in the market in the future.

Dr. MCDERMOTT. The chairman has talked on occasion about maybe opening up Medicare to let people under the age of 65 buy in, or have their employer buy in for them. Is that—would that be a safety net enough to satisfy your concern?

Dr. LEWIN. It might be, as long as—you know, I believe if we had an individual mandate in place across this country, and then we wanted to look at, you know—an attrition from employer coverage, then I think we would be fine.

But I think if we do a voluntary coverage, and then disincentivize employers, that we'll have a lot of people who—we don't want to create more uninsured people, or more people using the emergency room as their medical home. So we need to develop a change in the employer policy for those currently covered in a careful way, so as not to cast a lot of people out as uninsured.

Mr. WEIL. Congressman, I don't think there is great love and confidence in the long-term future of an employment-based system. It comes with some negative consequences.

First of all, I think we would all agree with Dr. Lewin, that you have to have something else. And right now, the "something elses" don't look very good. And even if the ship is sinking, there are a whole lot of people on it. And it's sinking slowly enough that if you accelerate the rate of sinking the human consequences are quite dire.

I do think that we also have a lot of differences around the roles that employers pay. Some employers are major innovators in the kind of motivation for integration, realigning incentives, investment and prevention, and some are—particularly smaller ones—don't have the resources, don't have the tools to drive that kind of innovation.

And, finally, employers are a source of pooling of risk—an imperfect one, by all tests. But again, if the alternative is moving out with complete fragmentation of risk, I think there are serious concerns there.

So, I think what you're hearing—at least I will speak for myself—is a lot of anxiety about the unraveling of the system, and frankly, not a lot of faith in some very global hopeful optimistic—and, in my view, unrealistic—assumptions about where people would land if we did unravel that system. And those are all reasons for caution, but not reasons, necessarily, to say, you know, "This is the best thing we would think of, if we were starting from a blank piece of paper."

Ms. RILEY. And I think we haven't had the policy discussion. We haven't made, as a country, the decision about what kind of health care we're going to have. So it's a tacit employer-based system. I do think we need to worry about it.

We need to have the discussion about whether we want to go forward with it and how, particularly given two factors. One is, increasingly as employers are constrained by the cost increases, they are shifting more on to employees, and we see a growing class of under-insured, people who don't really have coverage, but they're paying for it.

Dr. MCDERMOTT. Right.

Ms. RILEY. And, as the workplace changes and there is more part-time workers and more people not connected, or who move through employment very much more rapidly than our generation did, I think we do have to look very carefully and very quickly, because our assumptions that that employer base will stay the same clearly isn't correct.

Finally, though, I think the Kaiser Family Foundation and others have done some polling that suggests that, like it or not, the public is still committed to their employer-based system, and very worried about what might replace it.

Dr. MCDERMOTT. Yes. If you—that is, I think, what I said earlier, that while I don't—if I am understanding the panel, there are none of you who would say this is the end all and be all answer to our problem, but until we have a system that we can afford that the public will accept and the providers will participate in, we'd better go cautiously about just tossing the employer-based system overboard, and somehow see if we can move carefully there.

I wanted to ask one more question, and then Mr. Camp had another question.

In the past, in talking about universal coverage plans, and a plan that we had some years back, we had talked about subsuming Medicaid into Medicare—the idea that we've got two federal systems that often are different and disparate—and leave the states with the long-term care question, because they get lobbied the most heavily from oldsters like me. Little kids and poor people don't lobby very well. So every time there is a cut in state Medicaid, it comes out of the hide of the indigent and children, and the nursing homes do pretty well, thank you.

So, leave that portion with the states, and take the acute care into one system, whether it's Ms. Riley's idea of a universal primary care system, or whether it's some kind of Federal option, but not to—is there—how would that work in Massachusetts, Dr. Bigby?

Dr. BIGBY. Well, you know, the idea of merging Medicare and Medicaid would allow us to address several problems that we would love to address but, as many people on the panel have already pointed out, Medicare is a substantial player for a large percentage of the population. And without being able to formulate reforms within that system, it impedes our ability somewhat.

So, it would give us the ability to do larger experiments——

Dr. MCDERMOTT. And do the—I mean, Medicare, without a supplemental add-on, isn't necessarily the most generous or complete program. And it would seem to me that that would also be something Medicaid would do.

But if we got the kind of one—and I'm not sure there are many states where Medicaid pays more, or as much as Medicare, so I don't think I would get any fight from the docs and hospitals on it, but I don't know what it would do in the states.

Dr. BIGBY. It would allow us to align policies that we think would influence further reforms that have—that are more than just covering people and giving individuals access. It would allow us to do some of the system's redesign that have been talked about. It would allow us to get rid of some of the fragmentation in the system.

So, I think there are some potential positives that come out of that.

Dr. MCDERMOTT. How would Maine——

Ms. RILEY. Well, again, as the oldest state, Maine would be worried, because long-term care and people with disabilities are the driving costs of the Medicaid program. So it——

Dr. MCDERMOTT. No, I'm not saying that they wouldn't continue to get that, I'm just saying that we get rid of the acute care part of Medicaid, and let them continue—that would be their maintenance of effort, and we continue to share the cost, Federally, with them.

Ms. RILEY. I think, as long as there was sort of—usually, the states think the opposite: we will keep the acute care, and give the long-term care back to——

Dr. MCDERMOTT. Yes, I know that.

Ms. RILEY. But I think, for a state like ours that is innovating, it would be a shame to lose it. On the other hand, I do think there is great value, and you may not even have to take over the two programs, but just have the same standards, the same payment mech-

anisms, the same requirements, as a start, because there is such fragmentation in those two programs, and you could really drive efficiencies if there were just the same standards across the two programs.

Dr. MCDERMOTT. Would it help California?

Dr. LEWIN. I think I would be—I think it would be a good innovation, and worthy—it would be a daunting challenge to get it enacted, but I think it would ultimately be a very smart move.

Chairman STARK. Mr. Camp?

Mr. CAMP. Well, thank you, Mr. Chairman. I sort of heard a chorus of mandates this morning, but given that neither Senator Obama or Senator McCain support mandates, I think they're somewhat unlikely.

Is there any way, Mr. Haislmaier, that we could incentivize people to purchase health care, any sort of structure that could be created to do that?

Mr. HAISLMAIER. Well, yes. And I think what you do is you follow, essentially, the prescription that they did in Massachusetts, in designing their reforms, which is you find ways where you can make it easier for people to get and keep coverage.

So, for example, the Connector in Massachusetts enables people to go in there and get coverage in a single place. It enables an employer to say, "Look, I don't have to go out and negotiate with Blue Cross Blue Shield, or Fallon. I don't have to try to come up with a one-size-fits-all plan for my employees, and then the insurer won't give it to me unless I have 8 out of 10. I can just take my people down there and say, 'Here is the menu, here is the money, here is my agent, to help you walk through the menu and figure out what's best for you to spend the money.' You get the insurance you want, and you take it with you from job to job."

And if you simply include on that and say, well, you know, when the employer does that, they pick, one of the plans as the default start that everybody gets, and then they have a choice of something else, you're going to cover 80, 90-plus percent of people getting it, and you don't have to necessarily require them to do it.

In the end, yes, you will have some residual questions, especially if you bring in the individual market. And I think it's a very simple rule. I think the rules should be that if people buy and keep coverage when they're healthy, they should have, as part of the deal, a right to change coverage without penalties at certain times—not any time they want, but at certain times, like in open season—when they're older and sicker.

And so, what they did in Massachusetts is said, "Look, we're going to make it easier to get, we're going to subsidize it for people who need help subsidizing it, and we're going to produce the incentives to bring the costs down."

Chairman STARK. Thank you. I thank the panel very much. We are going to conclude the hearing. Before we do—well, we will conclude the hearing, and thank the panel.

I would like to announce to our guests that you can't go out the doors on that side of the room, there is a problem out here in the hall. Or, if you go out that way, you have to take your shoes off, and you can't take any gels or liquids with you.

[Laughter.]

Chairman STARK. We have to exit out into this hallway, if you will. Thank you very much. Meeting is adjourned.

[Whereupon, at 12:13 p.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

AARP, Statement

On behalf of AARP's nearly 40 million members, thank you for convening this hearing regarding state health care reform initiatives. Ensuring that all Americans have access to affordable, high quality health care is critically important to AARP members and their families. AARP has been centrally involved in state health care reform efforts through our offices in the 50 states, as well as in the District of Columbia and the territories. AARP has not only represented the health care coverage issues facing the 50+ population, but has been an advocate for health care consumers of all ages.

We have seen a great commitment in many states to provide affordable, high quality health care. But while the states can be laboratories of experimentation, they are often hampered by resource and legal constraints.

There are several lessons that can be learned from the successes and challenges states have encountered to date in their health care reform efforts:

(1) Comprehensive state health care reform relies upon a stable, clearly defined funding source;

(2) The employer role—and the applicability of federal standards under the Employee Retirement Income Security Act (ERISA)—is unclear, particularly as to how ERISA applies to shared employer funding for health care; and

(3) Cost containment is a critical element and must be administered carefully.

Need for stable, clearly defined funding

Comprehensive state health care reform is unlikely without stable, clearly defined funding. In most instances, without a stable federal funding source, state health reform efforts are jeopardized. For instance, Vermont's request for an exception from Medicaid rules for federal matching funding for subsidies to provide coverage for those up to 300 percent of the Federal Poverty Level (FPL) for its Catamount health care reform program was recently rejected, forcing a significant increase in premiums that will push some individuals back into the ranks of the uninsured. This federal action will also likely reduce take-up of Catamount Health, particularly at a time when many families are already feeling growing economic pressure. And Massachusetts, which successfully enacted comprehensive health care reform legislation in 2006, is now negotiating to continue to use Medicaid funds for the population at 200–300 percent of FPL that currently has subsidized premiums and out-of-pocket costs. A final example is Louisiana, where lack of clear federal Medicaid commitments was a major factor in the failure to enact health coverage legislation in Louisiana post Hurricane Katrina.

Recent experience demonstrates that in order for state initiatives to guarantee health security, federal funding sources are critical. Adoption of federal standards such as matching funds up to at least 300 percent of the FPL, requiring full Medicaid coverage for all those with incomes up to 100 percent of the FPL, and requiring uniform, minimum federal standards on coverage, cost and quality, would foster state reforms with access to affordable, high quality health care. Improvements in federal Medicaid financing policy could also address inconsistencies that arise from the wide variation in health status, number of uninsured, poverty rates, and state fiscal conditions found across the states.

Effective state health care reform efforts have relied upon federal assistance to serve all needy populations. Current state health care systems are highly fragmented, typically with dozens of programs, each serving different populations with different eligibility criteria and different benefits—all predicated on a hodgepodge of Medicaid and SCHIP limitations and waivers. This fragmentation is a particular issue for working families and older adults. We need to do much more to ensure that older adults enter their Medicare years in good health. Reforms need to take into account the premiums that target groups will face, otherwise older individuals or people with health problems can be charged significantly higher premiums, and many will still not be able to afford the coverage made available to them. In Massachusetts, for example, some 62,000 individuals with incomes over 300 percent of the FPL have been exempted from an individual mandate to purchase insurance because the premiums required are not affordable.

Lack of clarity about ERISA's impact

Employer-sponsored coverage for current employees and retirees continues to erode. While state insurance regulation can set standards for coverage for all health insurance products, states generally view ERISA as a barrier to shared financial responsibility with the business sector. Employer mandates were enacted in Vermont and Massachusetts, but they require a relatively small "contribution" from employers who do not provide coverage—$295 and $365 per employee per year, respectively. Even these requirements may be susceptible to legal challenge under ERISA.

Some states have enacted laws that encourage employers to provide coverage. For example, Maryland and Iowa offer subsidies to small employers, and Massachusetts provides employers access to lower cost insurance. But real health care reform will likely require state and Federal Governments, individuals, health care providers, insurers, *and* employers to share financial responsibility. At present, the scope of ERISA preemption on state health reform—as defined through the case law—is unclear, and the lack of clarity has contributed to inaction on state health care reform efforts. Therefore, further examination of how ERISA impacts state reform efforts is warranted.

Cost containment is critical

Stemming the tide of rising health care costs is a critical health care reform element. Unless we are able to rein in health care spending, affordable coverage will continue to elude millions of Americans. Cost pressure on employers and private individuals, as well as the pressure on public programs like Medicare and Medicaid, will continue to erode health care coverage and affordability.

AARP believes that consumers share responsibility for living healthier lives. We have supported state efforts to expand the use of preventive services and chronic disease management, including efforts to implement and appropriately reimburse care coordination. We have also supported programs that encourage and facilitate consumer use of these services, such as Vermont's Catamount and Blue Print for Health programs. These programs provide access to preventive care and chronic management services without consumer cost sharing and promote healthy behaviors through programs in schools, public health agencies, and other community-based sites, including the workplace. With the portion of the population with chronic diseases growing, these initiatives hold promise for long-term health benefits and cost containment in the public and private sector that will inure to the advantage of consumers as well.

Similarly, AARP believes that payment needs to be reformed to better align delivery system financial incentives with desired health outcomes; evidence should be the basis of clinical, consumer, and public sector decisions; and quality and safety should be improved by reducing waste, medical errors, and disparities based on socio-economic factors, race, and gender. These objectives could all be hastened, we believe, by accelerating the pace of adoption of health information technology. We support efforts to discourage over-utilization of medical services. Incentives need to be designed so that they produce the proper response, and that do not establish barriers to needed care or impose incentives that will have unintended consequences. Ultimately, these changes should help prevent the continued shift of medical costs to consumers and other payors.

Quality and price transparency is an effective tool in changing provider and patient behavior. Although information for consumer decision making is growing and improving, we must have realistic expectations for its use. For example, "good" information is not ubiquitous and does not always apply to the level of analysis most important to consumers; and the public still is not informed about where to find information on quality and cost even when it has been developed. Moreover, millions of consumers have poor health literacy or inadequate decision skills and require support to use information on quality and cost. Finally, designing information can be a source of contention among stakeholders—health care providers are particularly sensitive to publishing information on their performance. And collecting and reporting information is costly. Massachusetts has been trying to develop consumer-oriented cost and price reporting for over two years. Iowa and Minnesota recently enacted price and quality transparency legislation, but implementation has been slow due to controversial debates as to appropriate measures of quality and calculation methodology for cost.

All stakeholders, including patients, purchasers, and providers, should collaborate in identifying information that is published for consumer decision making. In addition, purchasers and providers should use evidence-based information for making their own contracting and referral decisions. Quality and price transparency are just two components of a multi-faceted approach to quality improvement and cost containment. Developing the evidence base to support the development of guidelines and performance measures that can be used as the basis for payment reform, as well as using health information technology to support better clinical and patient decisions, are additional components of an agenda to reform our state and national health care systems.

Conclusion

We commend the Subcommittee for holding this important hearing to focus more attention on state efforts to tackle health reform. We hope that this hearing is just

the beginning. AARP looks forward to working with you and your colleagues on both sides of the aisle to enact measures that broaden health care reform in the nation and the states.

Cleveland Jobs with Justice, Letter

Chairman Stark and Members of the Subcommittee on Health, Committee on Ways and Means:

We would like to thank you for the opportunity to provide this written testimony on behalf of the 59 member organizations of Cleveland Jobs with Justice. For over 16 years, we have been the unified voice of faith, labor and community organizations working together to promote workers' rights and social justice throughout Northeast Ohio.

We are providing this testimony today to voice our concerns with regard to the faulty, inequitable and unjust health care system and offer our alternative solution for comprehensive health care reform in the United States. The overwhelming statistic of over 47 million uninsured Americans clearly illustrates the efforts and energy needed to resolve the problem of the uninsured and/or underinsured extends well beyond our local communities and state-wide efforts. We need reform on a national level. We need you, our elected representatives, to take initiative towards a national single payer system, such as the one outlined in H.R. 676.

Cleveland Jobs with Justice believes access to health care should be viewed as a basic human right eliminating all barriers, especially those encountered by low income people and minorities.

Health care should be available to every American regardless of age, ethnicity, marital status, income, employment status, residency, pre-existing conditions or any other potential barrier currently thrown in the way of access. As long as our access to health care continues to be dictated by the insurance companies' bottom lines, we can rest assured the decisions about a person's wellbeing will continue to depend solely upon increasing profits.

The scope and impact of our broken health care system expands well beyond the sphere of citizens' health and is bearing negative effects on our country's already increasingly vulnerable workforce. The high costs paid by American businesses to provide health care to their employees is making it more and more difficult for American companies to compete in a global marketplace. In 2006, employer health insurance premiums increased by 7.7%—two times the rate of inflation. Employers are reacting to these dramatically rising health care costs by shifting increases to their employees, decreasing coverage, eliminating coverage all together or moving their operations to other nations where health care is less expensive. Retirees' benefits are constantly threatened or taken away, leaving them with employment related illnesses but no health insurance coverage. Many labor strikes are caused by an employer's attempt to reduce or eliminate health care benefits. Labor contract negotiations are often stalled over health care benefits. All of this is sending a clear and loud message that our health care system is in crisis and immediate, substantial reform is needed.

In addressing the faults and consequences of our health care system, Cleveland Jobs with Justice researched our current system and a variety of proposed reform models, finding faults in nearly all plans:

- Our current health insurance approach to coverage makes health care a commodity, not a right. HMOs and health insurance companies have a fiduciary duty to their stockholders to provide them with the highest profits possible. This means maximizing income while limiting expenditures. Of course, this is a significant conflict of interest with the fiduciary duties of health care providers to their patients, as well as in conflict with the patient's self-interest. Any new system must resolve this conflict and bring integrity to a process that frequently violates the Hippocratic Oath of "Do no harm."
- Plans that propose an expansion of programs such as Medicaid as a cornerstone for providing coverage to "all" are not acceptable. We liken them to building a structure on a sand dune. You know the sands are going to shift every budget cycle, depending upon how the political winds are blowing. Eventually that structure will collapse. What may be fully funded one budget cycle may be gutted the next. We certainly do not want to have to fight every budget for needed health care dollars. Just consider the recent battle over SCHIP. We should not have to rely upon a faulty funding structure for a reliable health care system.

- Personal mandates will result in people being moved from the list of "uninsured" to that of the "underinsured". Please remember, there is a significant difference between having "health insurance" and having access to "health care". Many people, even with "subsidies" are still only going to be able to purchase a bare bones insurance policy or may not be able to afford one at all. This results in a faulty system where people will still fall through the cracks. This predicament is best exemplified by the situation in Massachusetts where many people unable to afford the requirement under the State's personal mandate have been exempted from coverage. This entirely defeats the purpose of a personal mandate system as a strategy to expand affordable, accessible health care or in other words, universal health care.

Our exploration into proposed plans led us to the conclusion that the solution to health care in America is a truly universal plan, a single payer system.

The only real answer to providing health care to every American is a single payer model, as outlined in the U.S. National Health Insurance Act, H.R. 676, introduced by Congressman John Conyers. Not only is this act fiscally responsible, it guarantees access to health care to each and every American. By removing for-profit insurance companies, we eliminate:

- Excessive administrative costs
- Widespread underinsurance and bankruptcy
- Interference in physician decision making
- Lack of coordination, budgeting and planning
- Excessive complexity
- Regressive financing
- Continuously rising costs

We are not alone in supporting a single payer health care delivery system. H.R. 676 has been endorsed by 447 union organizations in 48 states including 110 Central Labor Councils and Area Labor Federations and 36 State AFL–CIO's. This list of union endorsers is continuously expanding. It is with great confidence that we hope you consider the support of the millions of members represented by these labor organizations far more substantial than the billions of dollars spent by health insurance lobbyists and pharmaceutical companies to deny Americans of their health and well being.

In closing, we ask you Chairman Stark and members of the committee, to act in the best interest of all Americans, not insurance companies, and support the only true solution to the problem of health care in America, the U.S. National Health Insurance Act, H.R. 676.

James Donbavand, Letter

Dear Chairman Stark,

I have been actively engaged in the field of healthcare finance for nearly 30 years in the area of acute care hospital financial management. As such, I have been responsible for rate setting, reimbursement, budgeting, cost accounting and program analysis.

I note there appear to be only physicians on your panel. I would suggest half your panel be comprised of nurses or hospital CEOs. They are more familiar with what the real issues are. Most non-routine patient care is delivered in hospitals. Physician offices are able to decline new patients based on their insurance or lack thereof. Hospitals aren't. Most that are not for profit would not.

It is my opinion that the issue you describe as a healthcare coverage instability', commonly referred to as "access", is one of financing. As you know from having been active in healthcare reform for decades, a hospital may not refuse, modify or curtail services to a patient based on ability to pay. There are laws governing the transfer process as well. Therefore, if that were the definition of access' I would suggest there is no problem.

In actuality, as you know, patients without insurance often have no physician. They use the county hospital or local ER as their primary care giver. Some say this drives up cost. I disagree. Efficiencies have been in place for years to deal with the variability of acuity in ERs. Again, patients are not turned away—so access is there, depending on your definition of the term.

Your issue, I believe, is that there are higher levels of care which you and I have access to that the uninsured and under-insured do not. CMS initiatives regarding quality which are being extended to reduce reimbursement will reduce this disparity. However, differences in quality of healthcare are similar to the differences that exist in education, for example choices between Harvard and the local Junior College, or between a good' high school with a higher tax base and one in an economically deprived area. Similar differences exist in the availability of legal representation in the criminal justice system.

Your intent, I believe, is to suggest that the overall quality of our country's healthcare system would be improved (because you are investigating its "instability"), if your committee can lay a foundation for socializing healthcare. I caution you to look to the models' held up in the past when this has been proposed. Canada's healthcare access is far inferior to ours. So is Great Britain's.

As people of my generation approach the time in their lives where healthcare is a priority, I think you will find that we will not as quickly agree that more government will solve the few problems caused by inadequate funding, and over-regulation. The introduction of PPS did not solve hospitals' problems, it only reduced their funding. Nor did the government's enabling the insurance industry to introduce Managed Care payment reduction systems. Neither did the creation of CMS. Nor did the more recent doubling of DRGs from 500 to 1000 by CMS with different weights for Medicare and Medicaid.

Access for all patients to the highest quality of care is a direct consequence of inadequate funding. Since it is not possible to fund the highest quality of care for all, the only solution is to lower the quality of care for those who have insurance. Socialization, of course is a dead end from which there is no return. I ask that you not destroy our healthcare industry by taking over complete control of it.

Thank you for the opportunity to share my opinions with you.

Sincerely,

James Joseph Donbavand
6326 Diego Ln.
San Antonio, Texas 78253

Jill Levine and Ray DiCarlo, Letter

Dear Chairman Pete Stark and Members of the House Ways and Means Health Subcommittee:

As Congress prepares to embark on national health care reform, we commend you for holding a hearing on the instability of health coverage in America. Thank you for allowing individuals and organizations, who were not invited to give oral testimony, the ability to submit a written statement for consideration by the Committee. This is the written testimony of Jill Levine and Ray DiCarlo, Ohio organizers for Healthcare-NOW, a national grassroots organization campaigning for privately delivered and publicly funded national affordable health care for all. Healthcare-Now is active in almost every state in more than 300 cities across the nation. As founding members of the Ohio Chapter of the Physicians For a National Health Program (PNHP), we have committed our time and resources to advocate for a comprehensive national health insurance program. PNHP is a non-profit research and education organization of 15,000 physicians, medical students and health professionals who support single-payer national health insurance. We hope the Committee will consider our testimony for inclusion in the printed record of the hearing.

In 1945, President Harry S. Truman was the first U.S. president to propose a prepaid health insurance plan for all Americans through the Social Security system. Over the following years, lawmakers narrowed the scope for health insurance recipients to the elderly and the poor. Twenty years later, in 1965, Lyndon B. Johnson signed H.R. 6675, (The Social Security Act of 1965), the Medicare and Medicaid Bill, (Title XVIII and Title XIX of the Social Security Act), providing comprehensive national health insurance for all Americans age 65 and over and certain low income persons.

Two Social Security Amendments were enacted in 1972 which expanded Medicare to provide national health insurance to two additional high risk groups—certain disabled persons and persons suffering from end-stage renal disease. Since 1972, little has been done nationally to assist the millions of uninsured middle class Americans. Absent of a national health insurance program for all Americans, states began taking the lead and designing their own state health reform initiatives. Massachusetts

(1988), Oregon (1989), Minnesota (1992), Vermont (1992), Washington State (1993), Hawaii (1994), Tennessee (1994), and Maine (2003) have each passed a state initiative, with different ideological plans and funding mechanisms, but all have ended in failure. Lessons learned from these state health reform initiatives:

- One state's regulatory power cannot force national insurers to offer a comprehensive benefit package, accept all residents for a large purchasing pool, and offer these packages at affordable prices.
- Program funding must be consistent and reliable during economic downturns. Since state government is constitutionally barred from running budget deficits, during an economic downturn, increased funding will be needed for the growing ranks of the uninsured and the subsidized poor. This is the very time there would likely be decreased tax revenue to fund the program.
- Poor states, with a high number of uninsured and low median household incomes, will never be able to pass the state tax increases needed to cover the uninsured and fund the massive subsidies needed for the poor to purchase their insurance.
- Health insurance costs cannot continue to increase at 2–3 times the rate of inflation and workers wages for sustained program survival. Program costs need to be reduced and controlled, rather than reducing patient benefits or increasing co-pays and deductibles.
- Once a state program is up and running, health care benefits entice individuals with expensive or chronic medical conditions to become residents of that state, leading to more applicants and higher costs than anticipated.

On their own, few if any states are economically, structurally, and statutorily capable of sustaining a comprehensive affordable health insurance program for all their residents.

Today, 47 million Americans, 16% of all U.S. citizens find themselves uninsured. Nationally, it has been estimated that 22,000 Americans died in 2006 because they were uninsured. [1] Is national health insurance a right for all Americans over 65 yrs of age, but not for all others? Is one American life more valuable than another? Some Americans have paid the ultimate price—their deaths have been attributed to a lack of health insurance, [2] while millions more are suffering daily. Almost 100 million Americans, 47 million uninsured plus an estimated 50 million underinsured, are now postponing needed care when sick, not getting recommended preventive health screenings, using emergency rooms for primary care, and/or amassing high medical debt.

In today's economy, America's health care cost trends cannot be fiscally sustained. Health insurance premiums are now rising at twice the rate of wages and inflation. [3] Health insurance rates have increased 73% since 2000[4] forcing employers to shift more of their health insurance costs onto their employees and to cut or eliminate benefits. The average premium for family health insurance today is $12,106/year.[5] The average American family is less able to afford basic comprehensive insurance to cover all medically necessary care, so they buy what they can afford at the time. Families with health insurance are now finding that the premiums, deductibles, and co-pays, leave them unable to pay for their share of any medical bills incurred. With almost half of all bankruptcies now caused by medical bills, millions of families are just one major illness away from declaring bankruptcy. Three-fourths of those bankrupt had health insurance at the time they got sick or injured. These health care trends need to be stopped. Now is the time for an efficient national health insurance program that is affordable for all Americans.

The U.S. National Health Insurance Act, H.R. 676, has already been introduced in the U.S. House of Representatives and currently has 91 co-sponsors. This single-payer national health insurance model puts the health of American citizens before the profits of the insurance companies. Studies by the U.S. General Accounting Office and many others have shown that this reform model will save at least 10% of all health care spending from administrative cost savings. Medicare spends 4 cents per health care dollar on administration while the private sector insurance companies spend 20–30 cents per dollar. Additional cost savings from eliminating the profit and overhead of the private health insurance industry, negotiating fair and reasonable drug prices through bulk purchasing of prescription drugs and putting all Americans in one large risk pool will be realized. These savings will combine to save Americans over 400 billion dollars annually which is more than enough to cover all of our nation's 47 million uninsured and the estimated 50 million underinsured without any increase in health care spending. The single-payer reform model is also the best model to control ever increasing health insurance costs.

H.R. 676 has considerable state, city, and county support. It was recently endorsed by the U.S. Conference of Mayors, representing over 1,000 cities with popu-

lations over 30,000. It has been endorsed by the Kentucky and New Hampshire House of Representatives, the New York State Assembly, and by dozens of cities and counties from Baltimore to San Francisco and from Warren County Tennessee to the majority Republican Renssalaer County Legislature in New York.

Public support is firmly behind a guaranteed national health insurance program for all. According to the latest nationwide survey, 65% of all Americans believe that: "The United States should adopt a universal health insurance program in which everybody is covered under a program like Medicare that is run by the government and financed by taxpayers."(6) Physician support is strong too. According to the latest survey published in the *Annals of Internal Medicine*, 59% of all physicians now "support government legislation to establish national health insurance." (7) The American College of Physicians, deans of major medical schools, former editors of the New England Journal of Medicine, and former surgeon generals are all supporting a single-payer national health insurance reform model. Union support for an "Expanded and Improved Medicare for All Program like H.R. 676, The U.S. National Health Insurance Act" is widespread. H.R. 676 has been endorsed by 447 union organizations in 49 states including 110 Central Labor Councils and Area Labor Federations and 36 state AFL–CIO's (KY, PA, CT, OH, DE, ND, WA, SC, WY, VT, FL, WI, WV, SD, NC, MO, MN, ME, AR, MD–DC, TX, IA, AZ, TN, OR, GA, OK, KS, CO, IN, AL, CA, AK, MI, MT and NE). International union endorsements include the SEIU, UAW, NEA, ILWU, NALC, IAM, Plumbers & Pipefitters (UA), Musicians (AFM), UE, CNA/NNOC, SMWIA, IFPTE and OPEIU. The General Assembly of the Presbyterian Church USA, the General Assembly of the Unitarian Universalists, the United Church of Christ, and the United Methodist Global Board of Church and Society have all endorsed H.R. 676.

Thank-you Mr. Chairman and members of the Committee, for providing us this opportunity to focus your attention on the need for a national solution to America's health care problems.

Jill Levine and Ray DiCarlo, Co-Chairs
Healthcare Now Committee
Patriots for Change
Physicians For a National Health Program—Ohio Chapter

Sources

1. *Urban Institute,* January 2008
2. "Care Without Coverage", *Institute of Medicine,* 2002
3. *KFF/HRET Survey of Employer-Sponsored Health Benefits, 1999–2007; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; HIAA, 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation, 1988–2007; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988–2007. Note: Data on premium increases reflect cost of premiums for family of four.*
4. Kaiser Family Foundation. (2005). *Trends and indicators in the changing health care marketplace.* Menlo Park, CA: Kaiser Family Foundation.
5. *Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007.*
6. *AP–Yahoo poll, December 2007*
7. *Annals of Internal Medicine,* April 2008.

The Milliman Medical Index, Letter

Chairman Stark, Ranking Member Camp, and Members of the Subcommittee:

Thank you for the opportunity for us to submit for the hearing record the *2008 Milliman Medical Index* (MMI). We commend the House Ways and Means Committee's Subcommittee on Health for holding this important hearing on state initiatives as Congress considers key healthcare reform issues.

Milliman, whose corporate offices are in Seattle, provides actuarial and consulting services in the areas of employee benefits, healthcare, life/financial services, and property and casualty insurance to the full spectrum of business, financial, government, and union organizations. Founded in 1947 as Milliman & Robertson, the company has 48 offices in principal cities in the United States and worldwide.

Our extensive knowledge of and experience in the healthcare arena may be helpful in your deliberations. This MMI submission presents our findings of healthcare costs and examines the drivers of those costs. The MMI has, for a number of years,

analyzed healthcare costs for the "typical American family of four" covered by an employer-sponsored preferred provider organization (PPO) plan. Our most recent MMI found that, while the average cost nationwide for this family is $15,609 in 2008, costs vary widely by geographic area: Atlanta ($14,845), Boston ($16,278), Chicago ($18,001), Dallas ($15,326), Denver ($15,289), Los Angeles ($15,861), Miami ($18,780), Memphis ($16,853), Minneapolis ($15,909), New York ($18,424), Philadelphia ($16,324), Phoenix ($13,868), Seattle ($14,340), and Washington, DC ($16,491).

We applaud the serious efforts of the Subcommittee to explore the nation's healthcare system and thank you for considering this submission. Please contact me if you have questions or would like any assistance our healthcare experts can provide.

Sincerely,

Lorraine W. Mayne, FSA, MAAA
Principal and Consulting Actuary
Milliman

Executive summary

Milliman's fourth annual study of average medical spending for a typical American family of four looks at key components of actual medical spending and tracks the changes over time. In addition to analyzing changes in national average health costs, the Milliman Medical Index (MMI) this year presents health-cost data for 14 major U.S. metropolitan areas.

The 2008 MMI's key findings include:

- The total medical cost in 2008 for a typical American family of four is $15,609 (compared with $14,500 in 2007).
- The average annual medical cost of the family increased by 7.6% from 2007 to 2008. While the $1,109 increase is a big expense, the rate of increase was down for the second straight year and is the lowest rate of increase in the past five years.
- There is a wide variation in costs across the country. Among the 14 metropolitan areas studied, healthcare costs varied by more than 35% from lowest to highest.
- While the overall rate of cost increase was down this year, the rate of prescription-drug cost increase was up for the first time since 2006.
- For the employee's share of spending on healthcare services, 2008 marks the second consecutive year of double-digit increase.

TABLE OF CONTENTS

Medical costs for 2008

The 2008 Milliman Medical Index (MMI) measures average medical spending for a typical American family of four covered by an employer-sponsored preferred provider organization (PPO) program.[1] The MMI also examines key components of medical spending and the changes in these components over time.

The MMI estimates the total annual medical costs in 2008 for a typical American family of four at $15,609, up from $14,500 in 2007. This is an increase of 7.6% over the 2007 MMI. The 2007 rate of increase was 8.4%.

Overall cost trends have declined over the last five years, from around 10% to the current 7.6%. Some of the forces leading to the recent modest downturn in trend are the result of temporary slowdowns in cost increases that may be offset by higher increases in other cost areas, some of which are discussed in greater detail throughout this report.

[1] The Milliman Medical Index is based on analysis of claims for millions of members in a wide variety of areas of the country. It takes into account estimated U.S. average provider payment rates and Milliman's analysis of historical claim data and understanding of trends in provider contracting. Utilization of medical services for a particular family varies significantly based on the family's ages, geographic area, health status, and random fluctuations due to unpredictable events.

Drivers of cost increases include:

- Increases in wages and cost of materials
- Improved technology and new drugs
- Economic incentives for healthcare providers
- Consumer demand
- Demographics
- Benefit mandates and regulations
- Cost shifting

FIGURE 1

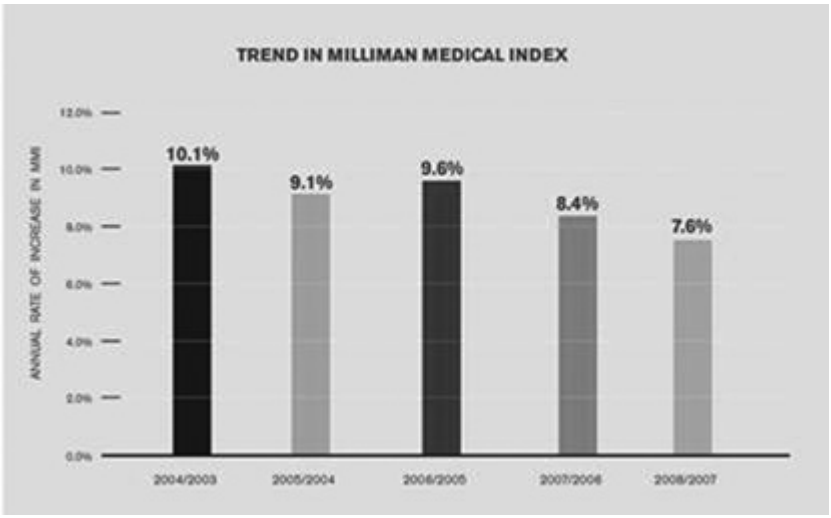
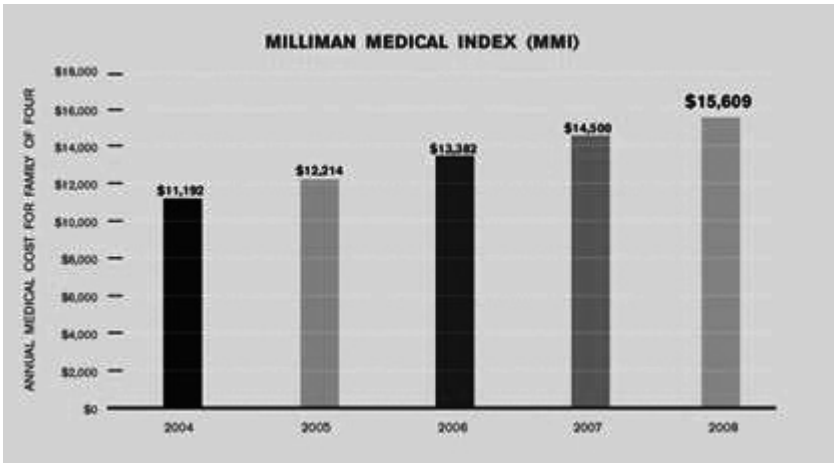


FIGURE 2

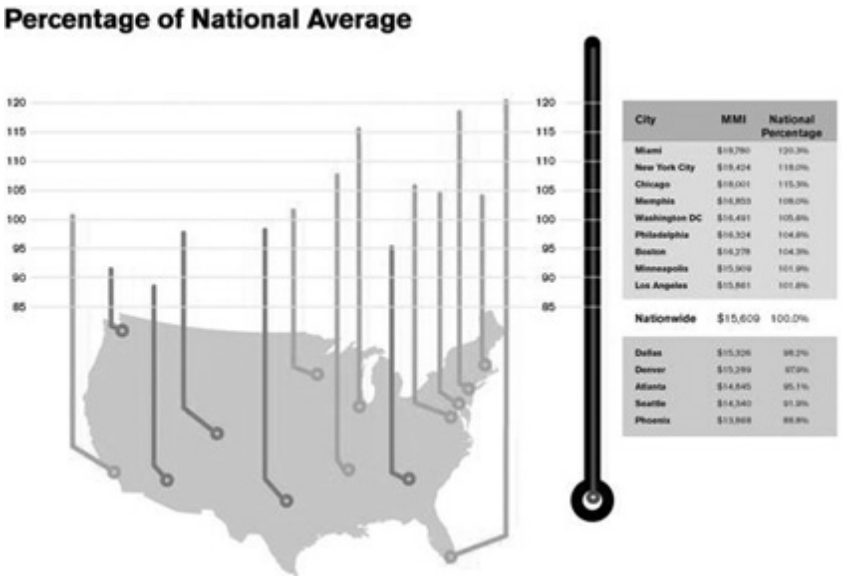


Geographic variation in health costs

Figure 3 shows healthcare costs for 14 major U.S. metropolitan areas. The costs vary by more than 35% from high to low. Cities in western, southern, and mountain states generally have lower costs than those in central and eastern states. The variations from city to city result from a complex array of regional factors, including medical-service treatment patterns, utilization of healthcare services, and costs per

service. The geographic indices were developed on a consistent basis using standard actuarial principles.

FIGURE 3



Medical cost categories

The MMI categorizes medical costs into the following major groupings:

- Outpatient facility services
- Physician services
- Prescription drugs
- Other services including ambulance, durable medical equipment, private-duty nursing, and home health

Figure 4 shows the distribution of the $15,609 total medical costs paid for by and on behalf of the typical American family of four. It includes both the portion of the costs paid by an employer's benefit plan and the portion paid by the family in the form of out-of-pocket cost sharing. Inpatient hospital and outpatient facility services combined represent 46% of the total annual medical costs, physician services represent 35%, prescription drugs 15%, and other miscellaneous services represent 4%. This distribution of costs reflects a modest shift in 2008 toward more pharmacy spending and less relative physician spending.

For the first time in three years, pharmacy cost trends exceeded other categories of service (see discussion on page 8). Physician costs once again increased at the lowest rate.

At 7.1%, the estimated inpatient hospital trend decreased relative to the overall national trend, while the outpatient facility trend dropped from 9.8% to 9.4%. The physician trend declined from 6.8% to 6.2% and is still the lowest cost increase of the major components. After two years of decreases, pharmacy trend increased by double digits at 10.6%. The increase in other services was similar to the overall increase.

FIGURE 4

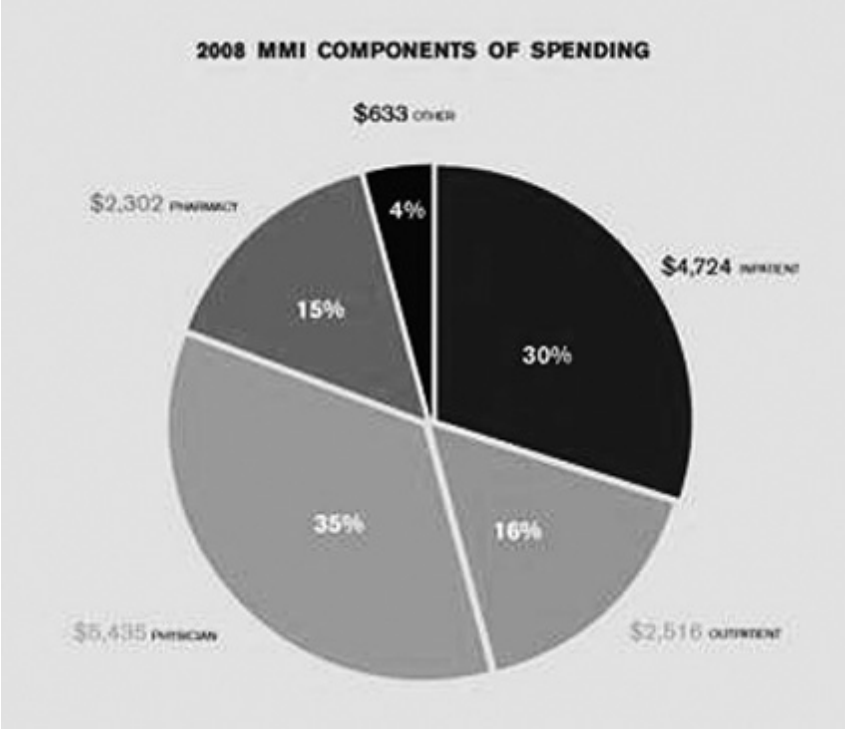
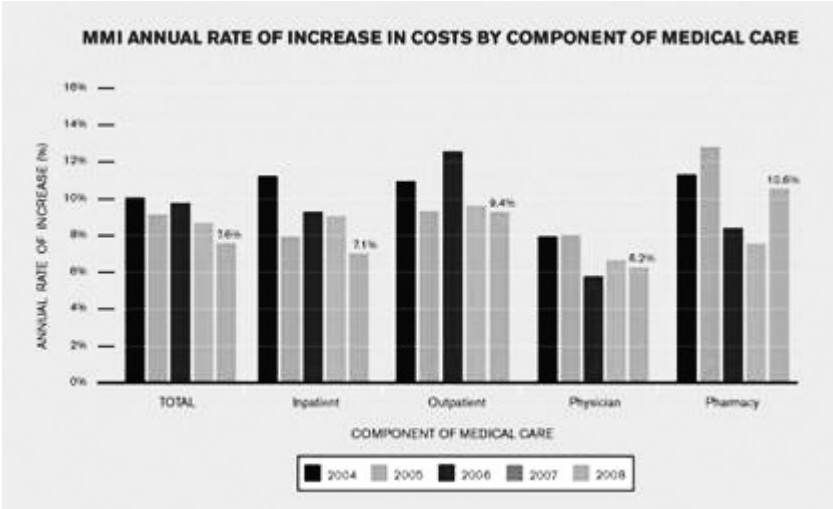
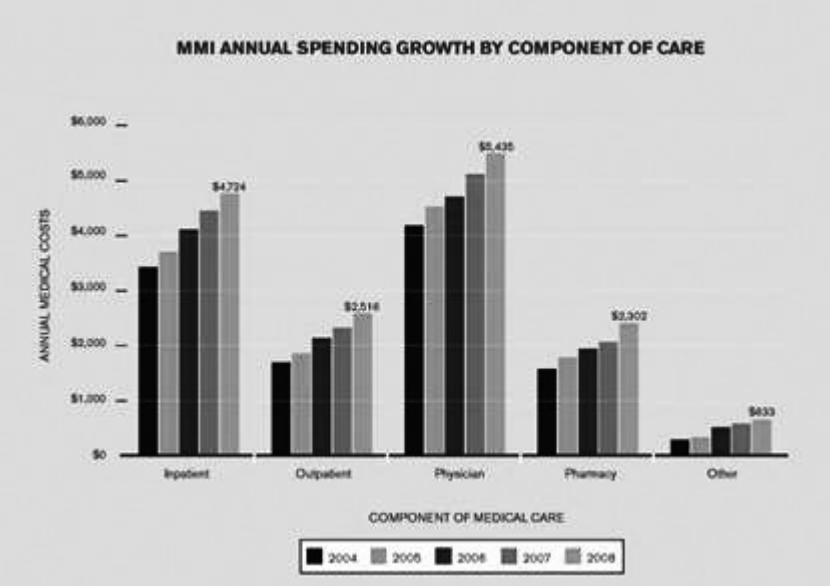


FIGURE 5



Hospital services and physician services contributed $530 and $315, respectively, to the $1,109 total increase in total annual medical costs between 2007 and 2008. Pharmacy's contribution was $221. Notably, the dollar increase for hospital and physician care is lower than the prior year's increase.

FIGURE 6



Variation in costs

Although the cost for a typical family of four is $15,609, any particular family could have significantly different costs. Variables that have a significant impact on average costs include:

- **Age and gender.** There is wide variation in costs by age, with older people generally having higher costs per person than younger people. For example, a male aged 60–64 has healthcare expenditures approximately five to six times as high as a male aged 25–29.[2] Variation also exists by gender. For example, partly due to maternity costs, a female aged 25–29 typically has healthcare costs approximately two and a half times as high as a male aged 25–29.
- **Individual health status.** Beyond cost variation due to age and gender differences, tremendous variation also results from health status differences. People with chronic conditions such as diabetes, asthma, and heart disease are likely to have much higher average healthcare costs than people without these conditions. In a typical population of people covered by an employer-group medical plan, approximately 7% will have no healthcare insurance claims during a given year, while approximately 22% of people will have claims that are at least ten times the cost of the average person.
- **Geographic area.** Significant variation exists in healthcare costs by geographic area, due to differences in healthcare provider practice patterns and average costs for the same services. Practice pattern differences result in patients with the same (or very similar) conditions being treated differently by different providers.
- **Provider variation.** The cost of healthcare depends on the providers used. In a recent study Milliman prepared for the Pacific Business Group on Health (PBGH), we found that California hospital costs varied widely because of differences in both billed charge levels and discounts that payers had negotiated.[3]
- **Insurance coverage.** The presence of insurance coverage and the "richness" of that coverage also affect healthcare spending. The cost- and utilization-reducing implications of leaner coverage are documented in Milliman's Consumer-

[2] Milliman 2008 *Health Cost Guidelines* Commercial Rating Structures

[3] Full report is available at: http://www.pbgh.org/documents/Milliman_OSHPD_Report_FINAL_20071017.pdf

driven Impact Study,[4] published earlier this year. The results of this study show that, after adjusting for different risk factors and the reduced utilization that is inherent in consumer-driven health plans (CDHPs), these plans produce savings of 4.8%. When people are responsible for more of the cost, they tend to engage the healthcare system less often, which minimizes unnecessary utilization.

Pharmacy trends

Although last year's MMI showed a drop in pharmacy cost trend for the second year in a row, the 2008 study identified an increasing cost trend that is expected to continue for the next few years. The declining trend of 2006 and 2007 was the result of increased adoption of generic drugs; that adoption rate has now slowed. Very few high-volume drugs will see their patents expire this year or for the next several years. Lipitor® is the next high-volume drug scheduled to clear patent, in 2010. Even though a drug's patent is scheduled to expire on a certain date, the generic version is not necessarily imminent. The recent delay in bringing to market a generic version of Nexium® (pushed back to 2014) provides a recent example.

While the cost trend is unlikely to decline in the next several years because of the dwindling introduction of generic drugs, individual employee benefit plans that provide incentives to shift from brand-name to generics can still favorably influence the nonspecialty drug trend. The nonspecialty drug trend may also be affected if some manufacturers increase certain drug prices in anticipation of expiring patent protections.

The increased use of coinsurance may help reduce pharmaceutical cost trend while value-based insurance design (VBID) strategies may increase pharmaceutical cost trend.

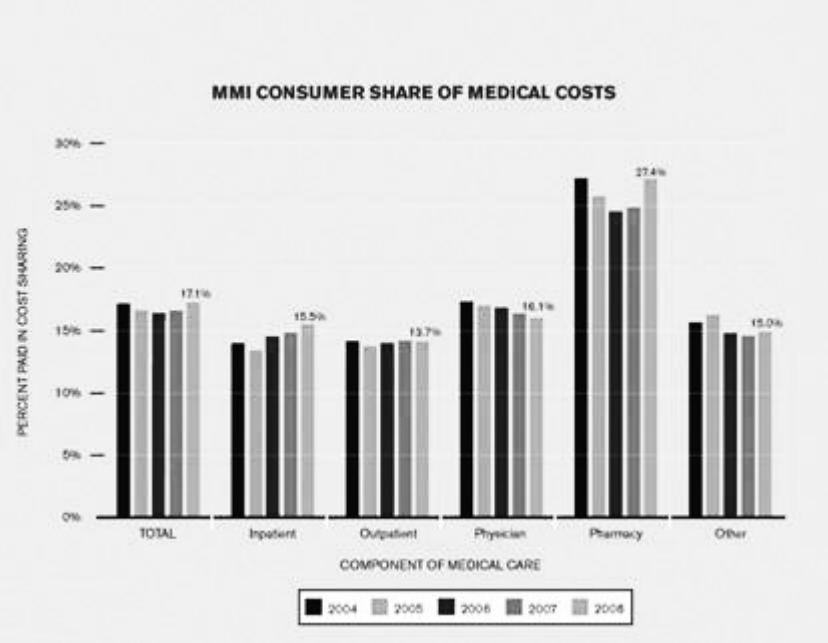
Specialty drug trend is projected at 17.6%[5] for 2008, continuing to increase its contribution to the total drug trend. Factors affecting the increase in specialty drug trend include:

- An increase in the number of specialty drugs coming to market, as well as new indications for existing drugs, particularly for rheumatoid arthritis, multiple sclerosis, and cancer.
- An increase in utilization and unit cost for many specialty products (e.g., increased utilization of anticoagulants and drugs indicated for rheumatoid arthritis, and increased unit cost for multiple sclerosis and cancer drugs).
- A shift of specialty pharmacy products from the medical-benefit category to the prescription-drug-benefit component.
- The shift in specialty pharmacy from the medical benefit to the prescription-drug benefit should result in a corresponding reduction in medical costs.

As in past years, consumers are bearing a larger share of the total cost of pharmacy services, especially proportionate to other components of care. However, consumers can often reduce their copays by requesting generic or formulary drugs. As many insurers move to coinsurance, patients may start to ask more questions about drug costs, and by so doing, the pharmaceutical dynamic could change.

[4] Milliman *Consumer-driven Impact Study,* April 2007, by Jack Burke and Rob Pipich. Full report is available at http://www.milliman.com/expertise/healthcare/publications/rr/consumer-driven-impact-study-RR04-01-08.php

FIGURE 7



Cost sharing

As was the case last year, healthcare costs have continued to shift from employers to employees. Previously, when trends were high, employers would absorb the majority of the cost increases to mitigate the effect on employees. But as trends have moderated in recent years, our data shows employers allowing the full trend increase, plus some of the past shortfall, to be passed on to employees.

While the dollar amounts paid by families for cost sharing have increased from 2003 to 2006, the rate of growth in out-of-pocket cost sharing has been slightly lower than overall trends during that time. In 2007 we saw a reversal to this movement, and in similar fashion our data for 2008 indicates average out-of-pocket cost sharing increasing at a higher pace than overall costs (10.5% vs. 7.6%).

Figure 9 shows that of the $15,609 total medical cost for a family of four under a PPO, the employer pays about $9,442 (60%), and the employee pays about $6,167 (40%). Just over half of the employee's share, or $3,492, is paid through payroll deductions, while $2,675 is paid in cost sharing at time of service.

In addition to increased cost sharing, employees are bearing a greater portion of the monthly premiums paid through payroll deductions compared with 2007. Unlike time-of-service cost sharing, employee contributions have a broad impact: they affect all participants, not just those who visit a healthcare provider. Based on Milliman's national survey of more than 4,000 employee benefit plans, as well as data from the Kaiser Family Foundation, we estimate employees' portion of the premiums increased 10.1% in 2008 over 2007. Although the employee contribution only represents, on average, about one-quarter (27.0%) of the total premium, the increase consumes a significant portion of wages for some employees.

FIGURE 8

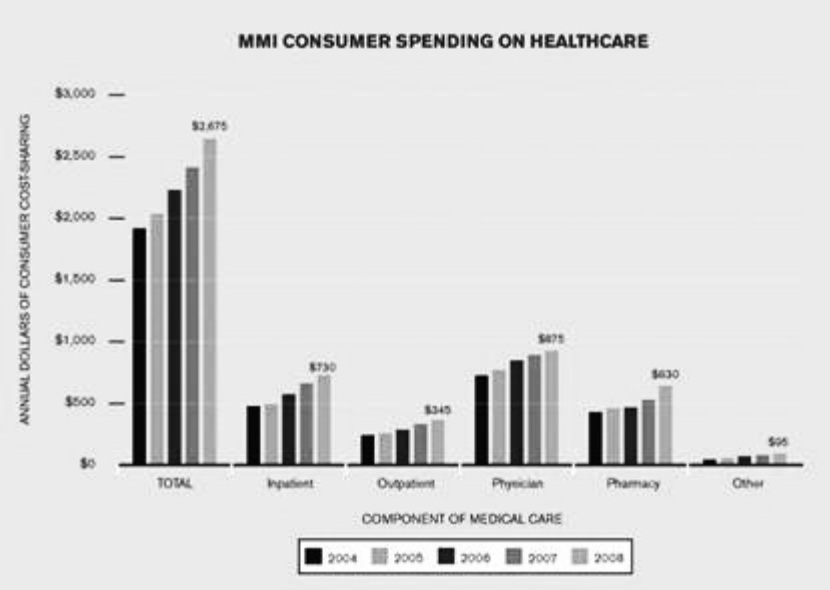
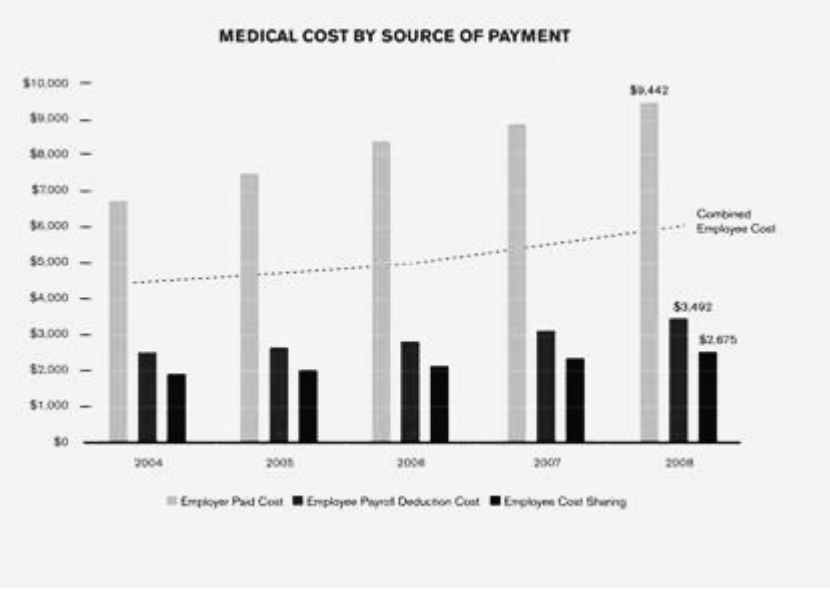


FIGURE 9



Cost trends in employee contributions lag behind the broader medical cost trend by 12 to 18 months. Thus, much of the 2008 increase for employee contributions is related to the higher past increases. The delay can be traced and attributed to a typical benefit-planning cycle. Employers set employee contributions only once each year, often months before the start of the plan year. Medical costs may sometimes increase at a higher rate than employers had initially forecast—and to more than overall compensation increase targets. In light of this, employers sometimes struggle

to distribute the increase between the employer's portion, employee cost sharing (copays, deductibles, etc.), and employee contributions (payroll deductions) while maintaining competitive plans to attract and retain employees.

Since 2004, the employer's share of costs increased at an average rate of 8.8% while the average rate of employee's total costs increased 8.5%.

Other healthcare trends

Employers continue to tweak plan designs and funding options to address the desire of participants for low-cost, high-value plans. In particular, CDHPs continue to grow in popularity, although the prevalence varies by region and size of employer. Generally, the largest employers and small employers have been the early adopters. (See Milliman's Consumer-driven Impact Study for a comprehensive analysis of CDHPs.)

The adoption of population health-management approaches, particularly wellness and health promotion programs, has become mainstream, yet medical cost savings outcomes have been inconclusive. Employers report positive outcomes for other metrics such as worker productivity, absenteeism, morale, and retention. The purchase of disease management services by employers recently leveled off with the continued lack of convincing evidence of medical cost savings.

Value-based insurance design (VBID) for pharmaceuticals is a relatively new trend that is intended to increase prescription-drug compliance for the chronically ill by reducing or eliminating copays for maintenance drugs. Medical cost savings is inconclusive at this early stage. In the short term, employer spending will increase as copays are reduced for those already compliant and drug utilization increases for those not compliant.

Technical appendix—Milliman Medical Index

The *Milliman Medical Index (MMI)* is a byproduct of Milliman's ongoing research in healthcare costs. The MMI is derived from Milliman's flagship health-cost research tool, the *Health Cost Guidelines*®, as well as a variety of other Milliman and industry data sources, including the *Group Health Insurance Survey*®, the *Milliman Mid-Market Survey,* and the *Consumer-driven Impact Study.*

The MMI represents the projected total cost of medical care for a hypothetical American family of four (two adults and two children) covered under an employer-sponsored PPO health benefit program, and reflects the following:

- Nationwide average provider-fee levels negotiated by insurance companies and PPOs.
- Average PPO benefit levels offered under employer-sponsored health benefit programs. For 2008, average benefits are assumed to have an in-network deductible of $366, various copays (e.g., $65 for emergency room visits, $19 for physician office visits, $11/25%/30% for generic/formulary brand/non-formulary brand drugs), and coinsurance of 16% for non-copay services.
- Utilization levels representative of the average for the commercially insured (non-Medicare, non-Medicaid) U.S. population.

About the *Milliman Medical Index (MMI)*

The MMI includes the cost of services paid under an employer health-benefit program, as well as costs paid by employees in the form of deductibles, coinsurance, and copays. The MMI represents the total cost of payments to healthcare providers, the most significant component of health insurance program costs; it excludes the nonmedical administrative component of health plan premiums. The MMI includes detail by provider type (e.g., hospitals, physicians, and pharmacies) for utilization, negotiated charges, and per capita costs, as well as how much of these costs are absorbed by employees in the form of cost sharing.

The 2008 report marks the fourth year of the MMI, although we report on data from the last five years. For historical context, we have used the MMI methodology and prior research data to calculate MMI values for 2004.

The MMI incorporates proprietary Milliman studies to determine representative provider-reimbursement levels over time, as well as other reliable sources, including the Kaiser Family Foundation/Health Research and Educational Trust 2007 *Annual Employer Health Benefit Survey* (Kaiser/HRET), to assess changes in health-plan benefit level by year.

About the *Health Cost Guidelines*®

Launched more than 50 years ago, the Health Cost Guidelines® are an industry standard, now used by more than 90 leading insurers to estimate expected health insurance claim costs. The seven-volume publication includes utilization rates for specific services and variations in costs in different parts of the country—critical

data used by traditional health carriers and managed-care organizations for product pricing. In addition, the Guidelines® provide utilization benchmarks for managed-care arrangements. The *Guidelines* are updated annually from core data sources, which contain the complete annual health services of more than 15 million lives as well as various specialized proprietary databases.

About the *Group Health Insurance Survey*®

The Group Health Insurance Survey® (formerly, HMO Intercompany Rate Survey®), launched in 1992, provides the industry's only survey measuring rate levels, trends, and experience for a uniform population, and benefit design for HMO and PPO plans from across the nation. Survey results are provided by metropolitan statistical area, state, region, and nationwide. The survey is used by managed-care organizations nationwide to compare their premiums, trends, and experience with those of their competitors. Published results include premiums, rate trends, anticipated future-year premium-rate change, inpatient utilization levels, physician reimbursement levels, medical expense ratios, and information on other current industry topics.

About the *Consumer-driven Impact Study*

The Consumer-driven Impact (CDI) Study, released by Milliman earlier this year, provides the first independent risk-adjusted analysis of CDHP savings. Developed in partnership with the National Business Group on Health, the CDI Study shows that CDHPs are creating savings of 4.8% for employers. After adjusting for induced utilization typically found in high-deductible plans, the savings amount to 1.5%. The more significant savings should not be dismissed, however, because induced utilization is a key component of the savings strategy inherent to CDHPs. These results reinforce the need for better consumer information. Actual savings are likely to increase when people have the consumer research resources they need to truly compare and shop for healthcare based on quality and cost.

○